DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	of Maryland /	-	rtment of H			ne 005	27002
	Physicia		1. Decedent's Name (First, Middle, Last) 9TANLEY	REEMAN				2. Date of Death Month AUGUST	Day Year	3. Time of Death
}	/Medic Examin		4a. Fecility Name (If not institution, give street and I NORTHWEST HOSPITAL CEN			4b. City, Town, or RANDALLS			4c. County of Dea	th
	Funeral		5. Social Security Number 6. Sex 120 M 2 F	7. Age (In yrs. last t	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ear) 9. Bir	thplace (State or Foreign puntry)
	Director		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Loc	ation		10/10/1	742	10d. Inside City Limits
	e Maryla	ctor	MD BALTIMORE		NGS M					1 ☐ Yes 2 ☑ No
	s with th	i Dire	10e. Street and Number 18 TATLER PLACE			10f. Zip Code 21117		10g	. Citizen of What C	ountry?
920	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Iteme 23a or 23a-f show ampting or other traumatic event, the Medical Evarifier must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married	ecedent Ever in U.S. Forces? s 2 □ No Give Dates:	If		spanic Origin? (Sn, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi Specify: WH	te, etc.
21215-0036	d within 72 ho giene, or than "natur ithe Medical	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	d) (1-4or 5+)	(Give I	ent's Usual Occupa kind of work done of O NOT use retired,	luring most of wo	orking	b. Kind of Business	/Industry
and	d be file antal Hyg ced othe c event,	Be	17. Father's Name (First, Middle, Last)		REEM	ΔN	18. Mother's Na	me (First, Middle, Ma	iden Sumame)	ALTSCHULER
Maryland	2 should and Me Is mark	2	19a. Informant's Name/Relationship (Type, Print)	15	9b. Mailin	g Address (Street a	and Number or R	ural Route Number, C		Zip Code)
	ss 1 end 2 of Health a item 27 ls other train		MARION FREEMAN / WIFE 20a. Method of Disposition	20b. Place	of Dispos	Sition (Name of latory or other place	- T		c. Location - City or	
Baltimore,	it. Page triment c rrient: If njury or	1	1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	m State	EL M	EMORIAL	08/1		RANDALLST	
Ba	Depa Impo any ii		Robert Two			00 REISTI		L LEVINSON	SVILLE, M	
	Pnysician i		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition	at caused the death. Do n each line.		or the mode of dying			t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	to (or as a consequence				70/101		
	be sit	ılner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequenc	a of).					
68760,	cate be executed physician and the burial-transit	ai Examlner	that initiated events c.	to (or as a consequenc	e of):					
x 687		Medical	IF FEMALE:							
.O. Box	The law requires that the death certifi ste has been signed by the attending cage 2 should be detached for use as	Physician/Me	in the past 12 months?	outcome of pregnancy e birth 2 Fetal dea agnant at time of death known		Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to	odeath but not resulting	g in the ur	ADLE OF			cco use contribute f	o the cause of death?
II Rec		Completed						24a. Was an autopsy performs	prior to	
Vital	Physician: this certificantal director,	o Be	25. Was case referred to medical examiner? 1 Yes No Hospital:	Inpatient 2 ER/	Outpatien	t 3□ DOA Othe	200	eath (Check only one)		acifv)
ion of	ding I. After fune	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 8 Pending 1 Natural 1 Natural 5 Pending 1 Nestigation 1 Pending 1 Nestigation 1 Pending 1 Nestigation 1 Pending 1 Nestigation 1 Pending 1 Natural 1 Natural 28b. Time of Injury 8 North 1 Natural 1 Natural 1 Natural 28c. Injury at Work? 1 Pending 1 North 1 Natural 28d. Describe how injury occurred								
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Sertific	3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At home, ilding, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
	e Hospil 24 hour e Funera letely fills	Medical (29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On the and m	the best of my knowled be basis of examination anner stated.	dge, death and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	ce, and due to the cau curred at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
		Me	29b. Signature and title of certifier	HYSICIAN		29c. License	number 1723.	A	d. Date signed (Mon	th, Day, Year)
	13			ause of death (Item 23:	a) (Type,	Print) NORT	HWEST OLV	HOST TA	CEN ROAD	WD 31133
	Sta Regist			2. Registrar's Signature	Goes					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death		1 N S N N P	27003
	1. Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month	Dey Ye	3. Time of Death
Physician /Medical	Virginia Iola Gault		15 200	
Examiner	Virginia Iola Gault 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Loc	ation of Deeth	4c. County of D	
Examine	Anne Arundel General Hospital Annapol	is	Anne	Arundel
Funeral		8. Date of Birth (Month, Dey, Y	(ear) 9.	Birthplece (State or Foreig Country) VA
Director	Usual Residence of Decedent	04 23	25	VA
end	10e. State 10b. County 10c. City, Town or Location			10d. Inside City Limit
Aary	MD Anne Arundel Glen Burnie			1 ☐ Yes 2√☐ N
within 72 hours effer deeth with the Maryland ene. Then "netural", or items 23a or 28s-f ahow he Medical Examiner must be notified at he modeled by Funeral Director	10e. Street end Number 10f. Zip Code	100	. Citizen of Whel	Country?
era 123	406 King George Drive 21061 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	U.S.	M ∙ Merican Indian,
permit. Pages I and 2 should be sined with the waryen permit. Pages I and 2 should be seen with the waryen begarings of Health and Mental Hygiene. Insportant: If I sen 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Armed Forces? If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)		Vhite, etc.
8 6 6	1 □ Never Married 2 Married 1 □ Yes X No 1 □ Yes 2 No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:		Specify:	Black
d Ferral	15 Decedent's Education 16a Decedent's Usual Occupation	16	b. Kind of Busine	
iet in in	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	g		
e de la	Elementary/Secondary (0-12)	B	alto Pi	ablic Scho
Hygin Hygin	12th grade 2yrs Paraprofessional 17. Fether's Neme (First, Middle, Last) 18. Mother's Name			
Mental Hygiene arked other than attc event, the To Be Com	Charlie Mason Hattie	Britt		
Men marke To	charre have		Pity or Town Sto	to Zin Code)
is m				
n 27	Daniel Gault JrHusband 406 King George Dr.	Glen Date 20	Burni 6 Oc. Location - City	Md 2106
T to T	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	C. Location - City	or rown, state
int: I	4 Donation 5 DOther (Specify) King Memorial Park 8/	19/05	Randall	lstown, Mc
Department Important: I Importa	21. Signature of Funeral Service Licansee 22. Name end Address of Facility			
OF S	March F/H West	n 3.1.1		2 21215
-	232 Parts Truet the disease or complications that caused the disable Do not enter the mode of dying such as cardiac of	Baltim respiratory arres	ore, Mo	21215
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or speck, or heart failure. List only one cause on each line.	,	*1	Approximate Interval Between Onset and Death
hysician	COOLS	1000		110000
/Medical Examiner	Immediate Cause (Final disease or condition a. SEPSIS; UNKNOWN SOU	RUE		HOURS
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ar si	b			
og physician end es the buriel-transit	Sequentially list conditions,			1
g physician end es the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):			
He the	that initiated events resulting in death) Last Due to (or as a consequence of):			
Mee S				
ettending for use	d,			
rthis certificate has been signed by the ettending director, page 2 should be datached for use To Be Completed by Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tob	acco use contrit	oute to the cause of dea
d by the ettendir latached for use Physician/N	CEREBROVASCULAR DISEASE	1 ☐ Yes	2 No 3	Probably 4 Unkn
be da	0,000,30			
been signed by the ettendir should be datached for use leted by Physician/A		24a. Was en		4b. Were autopsy finding available prior to
ate has been s paga 2 should		ponomie	, , , , , , , , , , , , , , , , , , ,	completion of cause of death?
has ga 2		1 ☐ Yes	off No.	1 ☐ Yes 2 ☐ No
e ag				1 1 19S 2 1 NO
nis certificate has t I director, paga 2 s To Be Compl	25. Wes case referred to medical examiner? Hospitel: Hospitel: Office of Death Content of			
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e a fe	1 Deleture 5 Pending (Month, Dey Year) Injury Work?	ou. Describe now	rinjury occurred	
octor: After by the fune iffication	2 Accident investigation M 1 Yes 2 No			
rect by	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 2	8f. Location (Stre City or Town,		r Rural Route Number,
rs aftar death. al Director: After t led in by the funare Certification:				
hour ly fill	29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Certifying Physician: To the best of			
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within 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral di Medical Certification: To	29b. Signature and title of cartifier 29c. License number			fonth, Day, Yeer)
	1 D31136	f	thousi	16,2005
10	30. Name end address of person who completed cause of death (Item 23a) (Type, Print)	1	D :	
K	30. Name end address of person who completed cause of death (Item 23a) (Type, Print) BRIAN C. WALLACE, MI), FOOS KILBRIDE	KOAD	, BACTI	nort, mozI.
	31. Date filed (Month, Day, Year) 32. Registrer's Signature	/		
State Registrar	AUG 1 8 2005 Many H. Royall a			

DHMH 16 Rev 6/95

		1. Decedent's Name (First, Middle,	Last)							2. Date of Month		ay	Year	3. Time of	Death
Physici /Medic		James Gatch								June			2005	10:22	A^{M}
Examin		4a. Facility Name (If not institution,	give street and number	r)		4b. City,	Town, or	Location	of Death		40	c. Count	y of Death		
		Anne Arundel Med					napol		0417 1			Anı		undel	
Funeral Director		5. Social Security Numberunk 6	5. Sex 7. A 1 M 2 □ F	ige (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of (Month,	Day, Year	r) 954	9. Birth	place (State ontry)	unk unk
2 *	}	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation								10d. Inside C	ity Limits
shor	ř		rundel		Arno									1 ☐ Yes	
atter used twith the walyand or items 23a or 28a-f show miner must be notified at	Director	10e. Street and Number	runder		ALIIO	10f. Zip	Code				10a. C	itizen of	What Cou		
P O D	<u>=</u>	1274 Caddle Dri	**-					2101	2					,	
TIS 2%	Funeral	11. Marital Status un	1. 12. Was Deceder	nt Ever in U.	.S. 13.	Was Deced	dent of His			cify Yes or Rican, etc.)	No-	USA 14. Ra	ce - Ameri	can Indian,	
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turel', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		dine	1 □ Yes :	2 X I No	Specify:				Specil	y: wh	nite	
within 72 hours after ene. than "neturel", or ite	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usua	al Occupa	ition uring mos	t of worki	na un	k 16b. l	Kind of E	Business/In	ndustry	ur
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e d at	Be	17. Father's Name (First, Middle, La	ast)				unk	18. Motne	ers Name	(First, Mide	ле, маю	an Sumai	me)		uı
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is I and 2 should of Health and Mer item 27 is marke other treumatic		20a. Method of Disposition		20b. F	Place of Dispo			EL Da		ate	-			own, State	
nent o ent: If ury or		1 ☐ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☑ Other (Spe	3 □Removal from State	e c	cemetery, crei	matory or o	ther place	9)			200.		Oily or 7	o mi, o tato	
Departicular Importanticular I		21. Signatury of Funeral Service Lin Ronal S	. Wade, Ni	ector	St	2. Name an Late A altimo	Anato	my B	oard 2120:	655 W	. Ba	ltim	ore S	Street	
*.		23a. Palt1. Enter the disease, of co shock, or heart failure. List or	omplications that caus	ed the deat										Approximat	
					n. Do not en	er the mod	de of dying	, such as	cardiac c	r respirator	y arrest,			(de provincia	e
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· ·	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number) The Jchns Hopkins Hosphi 5. Social Security Number 6. Sex 7. Age (In yet), last bir 20-08-6944 XIM 2IF 20	4b. City, Town, or L thday) If Under 1 Year Months Days	Mure (If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Pay, Year	c. County of Death	place (State or Foreign
	aryland show	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow					10d. Inside City Limits ↓□Yes 2□No
	n the Ma r 28a-f	al Director	MD . N/A 10e. Street and Number	BALTIMORE 10f. Zip Code		10g. C	itizen of What Cou	Λ
	s 23s c	ralp	102 MCDONOUGH STREET 11 Marital Status 12. Was Decedent Ever in U.S.	212			U.S.A.	ican Indian
920	be filed within 72 hours after death with the Maryland tal Hygiene. do other then "neturel", or items 23a or 28a-f show event, the Medical Erap iter must be notified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 [X]No	, Mexican, Puerto Ric	an, etc.)	Black, White	, etc.
21215-0036	within 72 ho ene. then "netur	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	ion uring most of working		Kind of Business/I	
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	* *		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final	not enter the mode of dying,	, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a	of):				12 hours
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σ.	as the	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause giver	n in Part I.	23e. Did tobacco		the cause of death?
Vital Records,	The ate ha	Completed				24a. Was an autopsy performed?	death?	topsy findings available completion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Other	26. Place of Death (C	4.	2 Flori	4
of	ling After fune	tlon; To		Time of 28c. Injury Work?	at 280	I. Describe how inj		ny)
Division	of or Attendia a ter death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f	Location (Street a City or Town, Sta	and Number or Ruste)	ral Route Number,
	To the Hospitel or within 24 hours a ter To the Funerel Director Completely filled in b	edical Ce	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	nd/or investigation in my oni	inion doubt accurred	at the time date a	nd aloca and due	to the cause(s)
	To the within To the compl	Me	29b. Signature and title of condition	29c. License	number	29d. C	late signed (Month), Day, Year)
•	2		9 Muniph de	The Britis	000	Clu	-gust	14-2005
	9		30. Name and address of person who completed cause of death (Item 23a) Mushopha Soler of The Johns Hopkin	s Hospital 600	w. wolfe	Street B	Hinere.	ND 21287
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 7 2005 32 Registrar's Signature	29c. License Res (Type, Print) S. Hespital 60c				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 **Physician** Hedges B. 9:a 13 Ethel 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Ivy Hall N.H. Middle River If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Date of Birth (Month Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country)
 T 37 **Funeral** 1 M 2 F N.Y. 061-16-6190 85 Yrs Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Baltimore Director NA Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21201 10F 1027 N. Cathedral Street Apt. Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes No 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Yes, Give Specify. Black Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "ne any injury or other traumatic event, the Madic once. Elementary/Secondary (0-12) College (1-4or 5+) Health Aide Home Care llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Ivory Rivers Hazel Boardley Richard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Rolland Daughter 4701 Shamrock Ave., Baltimore, Md. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 8-20-05 Baltimore, Md. Greenmount Cem. 22. Name and Address of Facility Baltimore, Md. 21202 21. Signature of Funeral Service Licenses March F.H. East 1101 E. North Ave. 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown þ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No lerel Director; After this certificate has been si filled in by the funeral director, page 2 should I Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 1 Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 Yes 2 No death. investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month). Day, Year) 29b. Signature and title of certifier 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signatur

P.0. Division of Vital Records,

AEM 05-05429 Wanda Hill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma			t of Health and N e of Death		ene UU5	2/00/
	Physici	an	Decedent's Name (First, Middle, Las Wanda	()		Hill		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, give	street and number)			Town, or Location of Death	August	11,2005 4c. County of Dea	1044am M
	Examin Funeral Director	er	3438 Ravenwood Av	7 C . 7. Age	(In yrs. last birthda 54 Yrs	Ba1	timore	8. Date of Birth (Month, Day, 10-29-	Baltime	ore City thplace (State or Foreign ountry) Md.
	2		Usual Residence of Decedent		10a Ciby Town or	. I anntina				Taga beside on the in-
	Marylar f ehow	ţō	Md. 10b. County		10c. City, Town or Ba	ltimore				10d. Inside City Limits 1 Yes 2 No
	h with fhe 23a or 26a at be noti	Funeral Director	10e. Street and Number 3438 Ravenwood	Avenue		10f. Zip	21213	10	g. Citizen of What Co USA	ountry?
980	be filed within 72 hours after death with the Maryland stal Hygiene. Indother than "netural", or Items 23a or 28a-f ehow event, the Madical Examination must be multified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	ver in U.S. 1	3. Was Dece If Yes, spe 1 \(\subseteq Yes	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	e filed within 72 ho al Hygiene. other than "netur vent, the Madical	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 10th grade	ucation de completed) College (1-4or 5-	(G life	ive kind of wo e. DO NOT u	al Occupation rk done during most of work se retired) nployed	ing	6b. Kind of Business Care Pro	·
<u>d</u>	Hygi other	0	17. Father's Name (First, Middle, Last)			DCIL DI		e (First, Middle, M		
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lary	s 1 and 2 should f Health and Men Item 27 fs marka other traumatic		19a. Informant's Name/Relationship (7				(Street and Number or Run		•	
	and lealth m 27 her tr		Jacqueline Ray	Sist			Monument S	_		
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Discemetery, of	Carmel	Cem. 8-1	9-05	Dundalk,	Md.
Ball	permit. Pag Department Important: f any Injury o		21. Signature of Funeral Service Lice	Valtus	1/m	Marc	nd Address of Facility h F.H. East	1101 E	timore, Mo . North A	
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Records,	w requires that s been signed I should be det	eted								robably 4 Unknown
al Rec	The ste h	Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Vital	Physicien: 'r this certifice ral director, p) Be	25. Was case referred to medical examiner? 1 [X]Yes 2 □ No	Hospital:	A [] E [] ()		04	h (Check only one		. Inapaction
Division of	ling Afte une	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	it 2 ☐ ER/Outpa / 28b. Time /Year) Injur		28c. Injury al Work? 1 Yes 2 No	28d. Describe ho		city) Inspection
Divis	safter death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, (Specify)	street, factor	y, office	28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Ai within 24 hours after of To the Funeral Directompletely filled in by	Medicai (29a. Certifier (Check only one) 1 ☐ Certifying Ph 2 ☐ Medical Exam	ysician: To the best o iner: On the basis of and manner stat	examination and/or	eath occurred r investigation	at the time, date and place, , in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29	c. License number	29	d. Date signed (Mont	
•	2		Utorle	M)			OCME		August 11	, 2005
			J. LARON WICH				111 Penn St	. Baltim	ore, Md 21	201
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 8 2	32. P gistra	r's Signature	sporte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Veer **Physician** CAROL ANN HOLLAND AUGUST 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** PARKVILLE BALTIMORE 1335 KENTON ROAD 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 M 2 XF Yrs 212-50-7012 Director 10/7/1946 MARYLAND Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other then "netural", or items 23s or 28e-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 X No Director PARKVILLE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1335 KENTON ROAD 21234 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐ Yes 2 f Yes, Give 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 7 and Mental Hygiene.
is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER NURSING HOME 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOSEPH CICHOCKI MAGDALINE ANDRYSZAK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If item 27 is 1 1335 KENTON ROAD NORMAN F. HOLLAND/HUSBAND PARKVILLE, MD 21234 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
DULANEY VALLEY MEM.
GARDENS ₩ Burial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If any injury or once. 8/19/2005 COCKEYSVILLE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME. P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician acuti Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner sclerosis multiple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transit Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1XYes 2 No 3 Probably 4 Unknown coronary outery Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No vascular has 1 Yes 2 No To the Hospitel or Attending Physicien: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0040208 8/18/05 Breuner B

5

State Registrar

AUG 1 8 2005

June Bremer MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Lutherville

	1- State RegisamEND ITEM #17 per fh g84	1 3/000	nuncate of Death			2005	2700
ician	Decedent's Name (First, Middle, Last)			2. Date of D Month	eath C	y Year	3. Time of Death
dical	Louise M. Hagan			08	05		10:30 A
niner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De	ath	4c.	. County of Death	
	2823 Fallsmont Drive 5. Social Security Number 6. Sex 7. Age (In)	vrs. last birthday)	Fallston If Under 1 Year If Under 24 H	rs. 8. Date of B	irth	Harford	ala an /State or Form
	1 N 2 N F	37 Yrs.	Months Days Hours M		lay, Year)		place (State or Fore ntry) 'yland
		City, Town or Lo	ocation				10d. Inside City Lim
Ö	MD Harford	Fallston	1				1 ☐ Yes 2 X
Funeral Director	10e. Street and Number	+ dilibeor	10f. Zip Code		10g. Cit	izen of What Cou	ntry?
₽	2823 Fallsmont Drive		21047			S.A.	
era	11. Marital Status 12. Was Decedent Ever i	n U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or N	10-	14. Race - Ameri	
by Fur	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		if Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 <mark>X</mark> No <i>Specify:</i>	erto Rican, etc.)		Black, White, Specify: Whi	
ted	15. Decedent's Education	16a. Deced	dent's Usual Occupation		16b. K	ind of Business/In	
Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done during most of v DO NOT use retired)	vorking			,
EO	6	Hom	memaker			Own Home	
Bec	17. Father's Name (First, Middle, Last) Kupisch		18. Mother's N	lame (First, Middl	e, Maiden	Sumame)	
٩	Gottlieb Kud isch		Clara	Koch			
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or	Rural Route Num	ber, City o	or Town, State, Zip	o Code)
	Dorothy A. Hagan (daughter)	2823	Fallsmont Drive	e - Fall:	ston.	Marylar	nd 21047
	20a. Method of Disposition 20	b. Place of Dispo	sition (Name of natory or other place)	Date		ocation - City or T	
			Memorial Gdns. 0	8/10/200	5 Be	l Air. M	aRYLAND
	21. Signature of Funeral Service Lieensee		2. Name and Address of Facility				
	E S' Yanalas		750 Belair Road				•
Г	23a. Part1. Enter the disease, or complications that caused the d						Approximate
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Ti in	Larcet To	1000	. 6	0	Interval Between Onset and Death
	disease or condition resulting in death)	IIVI	fur Ci ce	Wer	110	1	-
	Due to (or as a con	sequence of):	si m)				
9	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	01000	100				
Examiner		sequence of):					
Ka	cause. Enter Underlying Cause (Disease or injury	sequence of):	2 Mollins	\wedge			
100	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a con	sett	Mellitre	0			
aiE	Cause (Disease or injury that initiated events c.	sett	Mellitu	۵			
dicalE	Cause (Disease or injury that initiated events c.	sett	Mellite	۵			
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edicai	Cause (Disease or injury that initiated events resulting in death) Last C	sequence of):	Mellifu Detopic pregnancy	۵		23d. Date of deliv Month	ery Day Year
edicai	Cause (Disease or injury that initiated events resulting in death) Last C	sequence of):	Meller Dectopic pregnancy Other (specify)	۵			•
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DHMH 17 Rev 1/2001

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ADH SHIRLEY HOPEWELL Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Unpend item# 2,23a,27,28a-f, perMF, 853,3/27/06 TT State of Maryland / Department of Health and Mental Hygiene 05 - 5492Reg. No 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2005° AUGUST **Physician** Hopewell 0930 Ам Shirlev /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2503 VIOLET AVENUE APT # 508 S BALTIMORE | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) | O6 17 35 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M X XF Yrs Director 212-32-9761 70 Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow cical Examiner must be notified at Director 1X Yes 2 No Baltimore MD NA the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ U.S.A. 21215 iteme 23a 2503 Violet Ave Apt 508 S death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: þ Black 3 X Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " loth grade College (1-4or 5+) Hotels Housekeeping permit. Pages 1 and 2 should be file Department of Health and Menial Hy important: If item 27 is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude McSwain William Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1223 23rd St., Newport News, Va 23607 James Hopewell-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial 8/20/05 Arbutus, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig atula of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md ▶ 21215 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** No anatomic or toxicological cause of death disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of). Examiner attending physicien end for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown cate has been sly page 2 should b 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No this certificate 1 Yes 2 🗌 No 25. Was case referred to medical examiner?
1 ∑ Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To tuneral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Aiter t 5 Pending investigation 1 Natural 1 ☐ Yes 2 X No death. Fnd 8/14/2005 Fnd 9:00 a^M 2 Accident Director: 6X Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2503 Violet Ave. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide To the Hoepital owithin 24 hours and To the Funeral Dicompletely filled in Apartment Art. 508 S Baltimore, MD 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 16, 2005 OCME AUGUST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Southail MD 111 PENN STREET, BALTIMORE, MARYLAND, 21201 tamela

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

AUG1

8 2005

32. Registrar's Signature

Thomas 05-054		Ha	milton Jr	, Please	Type,or Ri	rint in Bl	ack Ind	delible	Ink,	Eŋsı	ire Al	l Ç <u>o</u> pies	s Are	Legible	e.	
NJM	10.2			Unpena :	Type or Pi Lten#46, 2 State of I	Maryland	7 Depa	ntment	of H	ealth	and M	ental Hy	/giene	nn	5 (7011
			1 - State Registrar 1. Decedent's Name	- (First Mindle I	ant)		Cer	tificate	of L	Death		2. Date of D	Reg. No.	.000	<i>)</i> (3. Time of Death
	Physici		Thomas	o Re	. /	nilton,	TR					Month August	Day		005	2225 ^M
	/Medio Examin		4a. Facility Neme (I	f not institution, gr	ive street and numb	er)		4b. City, T	own, or	Location	of Death	114545		County of [Death	
30			6524 St 5. Social Security N	. Helena		Age (In yrs. la	et hirthday)	Ba1	timo		24 Hrs.	8. Date of B	irth	0		IDRE
8	Funeral Director		213-68-	8037	12M 2□F	4	3 Yrs.		Days	Hours	Min.	Month, D	ay, Year)	757	Countr	ace (State or Foreign
9	and wo		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Lo	cation							10	d. Inside City Limits
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	death with the	Director	10e. Street and Nu	mber	17 /	0		10f. Zip					10g. Cit	izen of Wha	t Count	ry?
	heath v	Funeral	11. Marital Status	<i>⊃7.</i>	12. Was Decede	ont Ever in U.S	ue . 13. V			222 ispanic Or		ecify Yes or N Rican, etc.)	0-	14. Race -		
ဖွ	or iten	Fun		ied 2 Married	Armed Force 1 Tes 2 If Yes, Give			fYes,speci 1 □ Yes 2		Mexica Specify		Rican, etc.)		Black, \ Specify: /	. / .	tc.
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213	filed with Hygiene other tha						TK	ruck	D	LIVE		(First, Middl	o Maiden	Sumamal	4	
and	d be fi	To Be	17. Father's Name	(First, Middle, Las	/ //	. 1 km				1	5WS	,	ae	Cha	DM	an
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. is marked other than surnatic avent, the Ma	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2									te, Zip (Code)			
∑	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Heelth and Mental Hyglene. I them 27 is marked other than "natural", or iteme 23e or 28e-f show item 27 is marked other than "natural", or iteme 23e or 28e-f show other traumatic avent, the Medical Exartinar must be notified at	1	LINDA 20a. Method of Dis	Smith.	- Sister		685 ace of Dispo		iUV.	bar	Rd	Bate Dal	timer	ce, n		2/2/2 vn State
nor	m Q		1 🗆 Burial 2		☐Removal from Sta	ate ce	metery, crem Vi EU	natory or of	ner plac		9/1	2/05	3	thin	010	ml
Baltimore,	permit. Page Department important: if any injury or		21. Signature of Fu					Name and			lity to the	N FU	NEFA	t Ho	me	.P.A.
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	Dharisian	,	shock, or hee	ert failure. List on (Final	ly one cause on eac	ch line.									i	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)			tic (He		and a	атсо	DNOT	into	cicatio	n		+	
	Examiner	ē	Sequentially list co	onditions,	b. Ove to for	as a colloque									+	
7	ecuted and -transit	camlne	cause. Enter Under Cause (Disease or that initiated event	erlying rinjury	C	as a consequ	uncu ory.									
,00	e execui	l û	resulting in death)	Last		as a consequ	ence of):									
68760,	icate be exe physicien a s the burial-	dlcai			d						-					
Вох	eath certific attending p for use as	In/Me	IF FEMALE: 23b. Was deceder		23c. If yes, outco	ome of pregnan		DEctopic pro	eananci	,				23d. Date of		•
B	Attending Physician: The law requires that the death certificate be ex death. sctor: After this certificate has been signed by the attending physicien. story the funeral director, page 2 should be detached for use as the buriat	Physician/Med!	in the past 12 1 ☐ Yes 2 9 ☐ Unknown	□No		nt at time of de		Other (sp						Month		Day Year
P.O.	that the	Phy			contributing to dea	th but not resu	lting in the u	nderlying ca	ause giv	en in Part	1.	23e. Dio	tobacco	use contribu	ute to the	e cause of death?
rds	w requires been sign should be	ed by		······································								10	Yes 2	!□No 3[☐ Proba	ably 4 Unknown
eco	iaw re nas bee	Completed										24a. Wa	is an opsy formed?	24b. We	re autop or to con otb?	osy findings available inpletion of cause of
a H	an: The i tificate he tor, page		25. Was case refe	read to madical						OC Place	no of Doot	Yes	2 🗆 No		Yes	2□ No
- Şi	Physician: 1 this certificat al director, p	To Be	examiner?		Hospital: 1 🗆 Ing	patient 2 🗆 E	ER/Outpatier	nt 3 D0	A Oth			h <i>(Check^tonl</i>) me 5⊟Re		6 ⊠Other	(Specify	Scene
Division of Vital Records,	Jing Ph J. After th funeral	on:	27. Manner of Dea 1 ☐ Natural	5 Pending	Pagate of Month,		28b. Time o Injury		8c. Injur Wor	y at rk?		28d. Describe				unk
risio	Attendi death octor: /	flcat	2 Accident 3 Suicide	investigat 6 Could not determine	be 28e Place o	f Injury - At hos	unk me, farm, sti	M reet, factory		Yes 2				nd Number	or Rural	Route Number,
Dİ	rs after ai Dire ed in b	Certi	27. Manner of Death Natural Nat								24 S MD	St. Helena				
	To the Hospital or Attenwithin 24 hours after deat Within 24 hours after deat To the Funeral Director: completely filled in by the	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and manner as the date and place, and due of the cause(s) and due of the ca									er as sta d due to	ated. the cause(s)				
	To the within 2 To the complet	Med	29b. Signature and	title of certifier	and manne	H Stated.		290	. Licens	se number	•		29d. Da	ate signed (i	Month, L	Day, Year)
	7. 27. 0		16	Cort	leno)				O	CME			Au	igust,	14,	2005
			30. Name and add	lress of person wh	no completed cause	of death (Item	23а) (Туре,	Print)								
	St	ate	31. Date filed (Mo	nth, Day, Year)	32 Re	gistrar's Signat	ture /									
DU	Regist		A	UG184	UUD ME	yistiai s Sigilat	Sp	we								
Un	IMH 17 Rev 1/2	2001			•											

ORIGINAL

O5-5417 B.K.S IAN HARROP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ν.	HARROP		For State	State	of Maryla	•				and M		_	A A A	070	
			Registrar 1. Decedent's Name (First, Middle,	(ant)		Ce	runca	te of L	Jeath		2. Date of De	Reg. No	2000	3. Time of I	Dooth
	Physici		Ian H. Harro								Month AUG.	Da 10.	2005	3:05	P ^M
	/Medic Examin		4a. Facility Name (If not institution, 14 SOUTH POPP)	give street and	number) REET				Location of ORE C		1100.		:. County of Death	<u> </u>	F
-	Funeral		5. Social Security Number	6. Sex		s. last birthday)		er 1 Year	If Under 2		8. Date of Bir	th Your	9. Birth	place (State or	r Foreign
	Director		220-32-3399	1 M 2□F	74	Yrs.	Month:	Days	Hours	Min.	(Month, Da				
	pug M		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	cation					·····		10d. Inside City	v Limits
	Aaryla f sho	ō	MD			Baltim								1√ Yes	-
	288-1	Directo	10e. Street and Number			Daitin	_	ip Code				10a. Ci	tizen of What Cou		
	3a or	i Di	14 S. Popple	ton Str	eet				21201				USA		
	death	Funerai	11. Marital Status	12. Was D	ecedent Ever in	U.S. 13.	Was Dec			gin? (Spe	cify Yes or No Rican, etc.))-	14. Race - Ameri		
ဖွ	after or Its		1 Never Married 2 Marrie		Forces? es 2 □ No Give			2 No	Specify:	, Fuerto i	ncan, etc.)		Black, White,		
9	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23s or 28s-f show event, if a Medical Examination must be notified at	d by	3 ☐ Widowed 4 X Divorced	Year o	r Dates: 153	-55							WI	ite	
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ğ	offiled Hyg other	Be C	17. Father's Name (First, Middle, L	ast)		<u>F</u>	11701		18. Mothe	r's Name	(First, Middle	-			
<u>a</u>		To B	George Harro	p					Fr	ance	s Gran	.t			
Maryland 21215-0036	20 20 20	. 5	19a. Informant's Name/Relationsh	ip (Type, Print)			-						or Town, State, Zij		
	and leelth m 27		John Harrop/son		004				Plair		d Balt			1286	
Baltimore,	Pages 1 nent of H ant: If ite ary or ot		1									ocation - City or T	own, State		
Balt	permit. Pages Depertment of Important: If i eny injury or once.											ltimore S	Street		
			23a. Part1 Enter the disease, or o	complications the	at caused the de	ath. Do not en	er the m	ode of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition	A	theros	about					as Di		Se	Onset and D	eath
	/Medical Examiner		resulting in death)	Due Due	to (or as a conse	equence of):					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Lxammer	_	Sequentially list conditions,	b	to /or on a conso	augus of):									
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a conse	equanca or).									
~	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c	to (or as a conse	equence of):									
8760,	cate be executed obysicien and the burial-transit	dlcal		d						46					
9	rtifical ng phy as th	Medi	IF FEMALE.												
Box	eath certific ettending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Liv	outcome of preg re birth 2 ☐ Fe	tal death 3		pregnancy					23d. Dale of deliv	- /	'ear
o.	the e	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		egnant at time of iknown	death 5	Other (specify)					17.011.1		
<u> </u>	res that the de signed by the e be detached t	Ph	Part II. Other significant condition	s contributing to	o death but not re	sulting in the u	nderlying	cause give	en in Part I.		23e. Did	obacco	use contribute to t	he cause of de	eath?
ds	uires sign id be	d by									10	Yes 2	.□No 3□Proi	oably 4 🗷	(nknown
Ö	w requ	iete									24a. Was	an	24b. Were auto	opsy findings a	available
Division of Vital Records,	The lew requires that the death certificate be executed tables been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Completed		-							auto perfe	psy ormed? 22 No	prior to co death? 1 \(\text{Yes}		use of
<u>=</u>		BeC	25. Was case referred to medical examiner?	1					26. Place	of Death	(Check only				
>	hysic his ce Il dire	To	MYes 2□ No			ER/Outpatier			4 🗀 (40)				6)Other (Speci	MAT SC	ENE
Ĕ	ling P	io i:	27. Manner of Death 1 XNatural 5 ☐ Pending		ate ol Injury fonth, Day Year)	28b. Time o Injury		28c. Injury Work			8d. Describe	how inju	iry occurred		
S	death death ctor: / the	icat	2 Accident investig	ot be	ace of Injury - Al	home larm st	M fact		Yes 2□N		98f Location /	Stroot a	nd Number or Run	al Route Numb	hor
2	urs after ret Dire	Certification;	4 Homicide determin	uilding, etc. (Spe	cify)					City or To	wn, Stat	θ)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Medical	29a. Certifier 1 ☐ Certifying (Check only one)	xaminer: On the	the best of my ke e basis of examinanner stated.	nowledge, deat nation and/or in	h occurre vestigation	d at the tim on, in my op	ne, date and pinion, deat	d place, a th occurre	ind due to the ad at the time,	date an	i) and manner as s d place, and due t	stated. o the cause(s)	1
	with To t	Σ	29b. Signature and title of certifier	1000		1	2	9c. License	number C.M.E				ate signed (Month, $AUG.~11$,		
,			Plate	talla	More	1		U.(J •17 • E				AUG. 11,	2007	
			30. Name and address of person v	no completed c		em 23a) (Type, PENN S		T. B	ДТ.ТТМ	ORE	ARYT.AN	m 21	1201		
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Sig			,							
	Registr		AUG 18	2005	The second	S. San	Back .	,							

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			Registrar 1. Decedent's Name (Fi	rst, Middle, Last,	1		Oei	lineale or	Dealii	2. Date of De	Reg. No	2005	Time of Death
	Physici				KS, JR.					August	14,	^y 2005	0059A. M
	/Medic Examin		4a. Facility Name (If not	institution, give	street and number)			r Location of Death			. County of Dea	
			University					Baltimor				N/A	
	Funeral Director		5. Social Security Numb 2.1.9 96 84	32 🗏	7. A	ge (In yrs. last bir 24	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di MAR . 1	av. Year)	981 ^{9. Bir} C	thplace (State or Foreign ountry) D •
	and ow		Usual Residence of Dec 10a. State 10	b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	Mary -1 • hc	tor	MD.	N/A		F	3AL	TIMORE					1 ☐ Yes 2 ☐ No
	death with the Maryland me 23a or 28e-f ehow r.must be notified at	Director	10e. Street and Number					10f. Zip Code			10g. Cit	tizen of What C	ountry?
	1th will		2705 WE	GWORTH	LANE			212	30			U.S.	Α.
	after or its	by Funeral	11. Marital Status 1 Never Married 3 □ Widowed 4 □	2 Married	12. Was Deceden Armed Forces 1 Yes 27 If Yes, Give Year or Dates	? No		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☐No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or Ne Rican, etc.)	0-	14. Race - Ame Black, Whi Specify: BL	te, etc.
5	72 hours "neturel", adical Exe	ted		Decedent's Edu		16a.	Dece	dent's Usual Occup	ation during most of work	ina	16b. K	(ind of Business	
7	l within 72 hours iane. r then "neturel; the Medical Exa	Completed	Elementary/Secondar		College (1-4or	5+)	life.	DO NOT use retired	d)	nny			
7			12TH 17. Father's Name (Firs	t Adiedella (aat)		I	AB	ORER	4D Mathada Nam	- /Fire A Added		VING C	0.
מבו	od of the control of	o Be		HOOKS	, SR				18. Mother's Name MARGARI				
_	s 1 and 2 should be filed. I Health and Mentel Hyg. Item 27 is marked othe other traumatic event,	ĭ	19a. Informant's Name/			19b	. Mailir	ng Address (Street	and Number or Run	a <i>i Route Nu</i> mb	er, City	or Town, State,	Zip Code)
=	and 2 saith a n 27 is er trau		MARGARET	HOOKS	WILLIA			Wegwor				RE 212	
ore,			20a. Method of Disposit	ion		20b. Place of	Dispo	sition (Name of natory or other place	= -1	Date	20c. L	ocation - City or	Town, State
			1X Burial 2 ☐ Cr 4 Ø conation 5 ☐		lemoval from State	,		N CEM.	1	20, 20	05	BALTO	,MD.
ža	permit. Pag Department Important: eny injury once.		21 Signature of Funera	I Service Licens	96/	1		Name and Addre	ss of Facility SCRUGO	S FIIN	FPA	r. HOME	
<u>.</u>	40 E B G		1 xmai	derel	seving	41	11	412 E.	PRESTON	ST. B	ALT		21213
			23a. Part1. Enter the di shock, or heart fail Immediate Cause (Fina		ne cause on each					or respiratory a	arrest,		Approximate Interval Between Onset and Death
F	Physician /Medical		disease or condition resulting in death)	_	Gene	Let W.	are	eld H	ed				
	Examiner				(Due to (or a	s a consequence	or):	/					
		Jer	Sequentially list condition any, leading to infine cause. Enter Underlyin Cause (Disease or injur	ons.	Due to (or a	s a consequence	ofly:						
	cuted nd ransii	Examiner	that initiated events	y 1	·								
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0/0	ficate be executed physicien and s the burial-transit	edical									_		
×	certifi ding se as	//We	IF FEMALE:	2	3c. If yes, outcom-	e of pregnancy						23d. Date of de	livan
Ŏ :	death e etter	Physician/M	23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	iths?	1 Live birth	2 ☐ Fetal death at time of death		Ectopic pregnancy Other (specify)	,			Month Month	Day Year
	requires that the	by Pi	Part II. Other significan	t conditions cor	ntributing to death	but not resulting in	the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	o the cause of death?
Sora	en sig					···········				10	Yes 2	□No 3□P	robably 4 Ünknown
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	F es ge	Con								perfe Yes	ormed? 2 ☐ No	olean?	
<u> </u>	Physician: The ribis certificate har all director, page	Be	25. Was case referred to examiner?	_	locaital:			T out	26. Place of Deat		one)		
5 8	ਦ ਦੂ ਜ਼	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	<u></u>	lospital: 1 ⊠Inpat 28a. Date of Inj	ient 2 ER/Ou	tpatien Time of		4 Nursing Ho	me 5 Res			cify)
5	Attending r death. ector: After by the fune	ertification:		Pending investigation	(Month, D	ay Year)	njury	Wor	k? Yes 2 No	Sulni	TION INJU	of a	
INISION	Atten r dea ector by the	Ifica	3 ☐ Suicide 6	Could not be determined	28e. Place of Ir	jury - At home, fa		IN MALE		28f. Location	Street ar	nd Number or R	ural Route Number,
=	s afte s afte at Dir	Cert	4 DHomicide		building, e	itc. (Specify)				S-IK	wn, State	2 600 h	espertelare
	lospii Unour unera	edical	29a. Certifier 1	Certifying Phys	sician: To the bes	t of my knowledge	death	occurred at the tir	ne, date and place, pinion, death occur	and due to the	cause(s	and manner as	s stated.
,	To the Hospital or Attending is within 24 hours after death. To the Funerat Director: After completely filled in by the funer	Medi	one)		and manner s	tated.				od at the time,			
,	5 ¥ 5 g	-	29b. Signature and title	or certmer	117/	,		0.C.M	e number [.E.		Augu	ite signed <i>(Moni</i> 1St 14,	2005
	()	7	30. Name and address	orline l	1. Fry	hash (trans and	(T):==	Print)					
	4		THEUD & A		inpleted cause of	eath (Item 23a)	(≀урө,	111 P	enn Stree	t, Balt	imor	re Maryl	and 21201
	Sta	te	31. Date filed (Month, D			trar's Signature	1						
	Registr	ar	AUG	1 7 200	A SECOND	v A.	GOL	we					
DHA	411 47 0 4/00	204											

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day **Physician** Aug 13, 2005 7:00a M Alvorady Hubbard /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3631 Valley #9 Baltimore Terrace Randallstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Yrs. 87 20,1917 N.C Director 246-10-5148 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show ust be notified at 1 ¥ Yes 2 No Director Baltimore Randallstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a 21244 Valley Terrace #9 Δ 3631 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner m Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black ō Baltimore, Maryland 21215-0036 þ 3 ₩idowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) than Elevator Operator/Supervisor Veteran Admin. llth marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hy ent: If item 27 Is marked oth Be Maudie Best 2 John Bobbit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 376 Jefferson Ave. Brooklyn, N. Y. 11221
ce of Disposition (Name of Date 2 c. Location - City or Town, State Margie Austin/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) = 5 ortent: I GREENMOUNT CEMETERY AUG. 17, 2005 Philadephia, PA. 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 21. Signature of Funeral Fernica Liberts permit. Deper Import any in PRESTON ST. BALTO. 1412 E. MD 21213 Approximate Int val B. ween On et an Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). colunte disease Examine The law requires that the death certificate be executed as the burialattending physician P.O. Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ 10 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Be Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 2 NO 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mann Death 28a. Date of Injury (Month, Day Year) After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation dealth. 2 Accident after death Director: in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō within 24 hours a To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check o one) 29c. License number 29b. Signature and title of certifu re and ad ess of person who completed cause 31. Date filed (Month, Day, Year) AUG 1 7 Zuup Registrar

Edwin William James

			State of Maryland				d Mental Hy	giene		
			= State Registrar	Ce	rtificate of L	Death		Reg. No 1	5 27015	
	Physicia	an	1. Decedent's Name (First, Middle, Last) ENUN William James				2. Date of Dea	Day \	Year 4:17 PM	
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of D	AU6	4c. County of	102	
	Examin	er	Baltimore VA Medical Cent	er	Baltil	nove		٨	I/A	
,	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. In	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	tin (Month Da	h y, Year)	9. Birthplace (State or Foreign Country) Marykand	
١.	Director		212-48-9615 1XIM 2 57				Dec. 24	, 1947	marykana	
	yland how		10a. State 10b. County 10c. City	, Town or Lo	ocation				10d. Inside City Limits	
	r 28a-f ehow	Director	Maryland N/A		Baltimor	.e			1 Yes 2 No	
	with the	Dire	100. Street and Number 4415 Furley Avenue		10f. Zip Code	206		10g. Citizen of Wh		
	ns 23	Funerai	11 Marital Status 12. Was Decedent Ever in U.	S. 13.			(Specify Yes or No- uerto Rican, etc.)		- American Indian,	
٥	n 72 hours atter death with the Maryland "neturel", or Items 23a or 28a-1 ehow alical Exeminer must be notilised at	Fur	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Never Married		If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	n, Mexican, Pi Specify:	ueπo Hican, etc.)	Specify:	, White, etc. White	
5-003e	ural',	d by	3 Widowed 4 A Divorced Year or Dates: 1971		edent's Usual Occupa			16b. Kind of Bus		
<u> </u>	"na	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	furing most of	working		Telephone	
717	filed within Hygiene. other than	Com	12th Grade	Fiel	d Technic		:	Company	1	
ב	Q to D e	Be	17. Father's Name (First, Middle, Last) Edwin William James, Ir.				Name (First, Middle, erûne R.	Maiden Sumame, Miller)	
Maryland	thould a Mer marke	Jo	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street a		r Rural Route Numbe		itate, Zip Code)	
	s 1 and 2 should t Health and Mer Item 27 is marke other traumatic		Mrs. Margaret Wess (sister)						MD 21050	
or G	0 0				osition (Name of ematory or other place		Date		City or Town, State	
Baitimore,	permit. Pages Department of I Important: If It any injury or o		'4 □Donation 5 □ Other (Specify)		Crematory		-		e, Maryland	
g	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licensee				Schimunek , Baltimo,			
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.						Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Taily	re				Onset and Death One Woels	
	/Medical Examiner		resulting in death) Due to (or as a consequence of the consequence of	uence of):	1 10 1	(100.0			and Vacio	
	Lxammer	Sequentially list conditions b. CLY 1108 (S. S. S								
4	uted d ansit	if any, leading to immediate Due to (or as a consequence or): cause. Enter Underlying Cause (Disease or injury								
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8760,	cate be executed physician and the burial-transit	dicai	d					<u>. </u>		
× 6		/Me	IF FEMALE: 23c. If yes, outcome of pregnant					, 23d. Date	of delivery	
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	The taw requires that the ten by the bas been signed by the bage 2 should be detache	l by	Part II. Other significant conditions contributing to death, but not rest	illing in the t	underlying cause giv	en in Part I.	1 🗆 1	11	3 ☐ Probably 4 ☐Unknown	
Records,	w requ	letec	TO STATE OF					an 24b. W	ere autopsy findings available	
Ř	hysician: The law his certiticate has t I director, page 2 s	omp					- autor	psy pr prmed? de	ior to completion of cause of eath? ☐ Yes 2☐ No	
īa		BeC	25. Was case referred to medical examiner?				Death (Check only o			
> >	Physic this ce al dire	ပ္	1 Yes 2 No Hospital: 1 Appatient 2	ER/Outpatie		4 Nulsii	ng Home 5 Resid	dence 6 Other		
00	ding h. h. After funer	tion	27. Manner of Déath 1 Dataural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2 □ No	200. Describe i	now injury occurre	u .	
Division of Vital	Atten ar deal ector: by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined building, etc. (Specific	ome, farm, s	treet, factory, office		28f. Location (: City or Tox		r or Rural Route Number,	
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartification death in the funeral director, completely tilled in by the funeral director,	edical	29a. Certifier (Check only one) (Check o							
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed	(Month, Day, Year)	
			Daniel My Cyry M	0	161	162	<i>f</i>	11/6/15/	2005	
	4+1		30. Name and address of person who completed cause of death (Item	1 23a) (Type	Sneme S	St R	altimas	Mh 2	1201	
	Sta	ite	31. Date filed (Month, Day, Year) 32 Registrar's Signa		1 4.	4 - 1/	2 1 4 (1 1 (a)		- 1	
	Registi		AUG 1 8 2005	J. A.	novel					

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			1 - For State Registrar	State of Marylan		ent of Health ate of Deat		ntal Hygiene Reg. Nő		27016
	Physici	an	1. Decedent's Name (First, Middle, Last)	-			2.	Date of Death Month Da	Year	S. Time of Death
	/Medic		Hrdena J	ohnson				Ugust 14	+ 2005	
A	Examir	ier	4a Facility Name (If not institution, pive s	NE	2	DAIE MU)RE		County of Deat	
ŀ	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.	Yrs. If Uni		s Min.	Date of Birth (Month, Day) Year)	7 1/1	thplace (State or Foreign
	Maryland -f show	tor	10a. State 10b. County	100	y Town or Location	E				10d. Inside City Limits
	h with the	Funeral Director	10e. Street and Number PLE	HON St		Zip Code)	10g. Cit	izen of What Co	ountry?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Experiment must be notified at		1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		cedent of Hispanic pecify Cuban, Mexic		y Yes or No- an, etc.)	14. Race - Ame Black, White Specify:	
00-9	2 hours atural', cal Ex	ted by	3 Widowed 4 Divorced 15. Decedent's Educ	Year or Dates:	16a. Decedent's U	sual Occupation		16bgK	~	Ipdustry
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Maryland	ould be filed Mental Hygid arked other attic event, iii	To Be C	17. Father's Name (First, Middle, Last)	SON		18. Mo	Acther's Name (F	irst, Midale Maiden	Shall	
	1 and 2 should Health and Men Iem 27 is marke		199. Informant's Name Relationship (Ty)	(Sister)	19 Mailin Addre	ss (Stree d Nun	nb r or Rury A	oute and city of	r T. M. Jate, 2	21000
Baltimore,	Pages 1: nent of He ant: If item ary or oth		20a. Method of Disposition 1 Bunal 2 Cremation 3 R 4 Donation 5 Other (Specify)		lace of Disposition (formatory of	lame of riother place)	8-19-	05 OA	cation City of	Town, State
Balti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service License	Galmore .	22. Name	and Address of Fa	cilla (16)	DHOIS	34/60/	V6.2012
Б	\$. ₁₀₀		23a. Part1. Enter the disease, or complishock or heart failure. List only or immediate Cause (Final	cations that caused the death	h. Do not enter the m			espiratory arrest,		Approximate Interval Between Onset and Death
5	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	uence of):	1 0151	EASE.			
100		ner	Sequentially list out ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (r as a consequence						
8760,	icate be executed physician and s the burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	uence of):					
O. Box 68	ne death certif the attending thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3 ☐ Ectopic	c pregnancy (specify)			23d. Date of deli Month	ivery Day Year
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of Vital Records,	The ate h	Completed	Nementia					24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were au prior to death?	topsy findings available completion of cause of 많던 No
Vita Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:		Other	ace of Death (C			
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	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b	edical	29a. Certifier (Check only one) 2 Medicel Exemination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occum tion and/or investigati	ed at the time, date on, in my opinion, d	and place, and leath occurred	due to the cause(s) at the time, date and	and manner as place, and due	stated. to the cause(s)
)	withi To II	M	29b. Signature and title of certifier	mO		D35	102	ano	e signed (Month	7 2005
	H		30. Name and address of person who co		n 23a) (Type, Print)	les Stri	IN BA	Itimore	Mar	Ilano
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pegistrar's Signa						

DHMH 17 Rev 1/2001

ORIGINAL

		Amend 1 - For State	Please T item#10a-c	ype or Prii e f 16b State of M	nt in B perFh aryland				All Copie: Mental Hy			0701
Physic	ian	Registrar	ne (First, Middle, Last)		k	Cer Chov	tificate of	Death	2. Date of D	Da	ay Year	3. Time of Death
/Medi Exami Funeral Director		4a. Facility Name Howard 5. Social Security 364-30-7 Usual Residence	(If not institution, give somety General 16. See 172	neral H	ospit		4b. City, Town,		S. 8. Date of B	irth Day, Year) Cou	h A
Maryland	tor	10a. State	10b. County Hillsboro	ıgh	Ta	Town or Lo						10d. Inside City Limit
th with the 23a or 28s	ai Director	10e. Street and N 6020 W	ilshire Dr instrel Way	• *			133615°	21045		10g. C	itizen of What Cou	untry?
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Medical Eventret matter excilling at	by Funerai		rried 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:			Vas Decedent of Yes, specify Cu ☐ Yes 2 1 No	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or N rto Rican, etc.)	lo-	14. Race - Amer Black, White Specify:	
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and 2 should be file auth and Mental Hy n 27 is markad oth lar traumatic event	To	19a. Informant's I	Name/Relationship (Ty) Michael Fe				g Address (Stree	at and Number or F		ber, City		ip Code)
Page nent cant; if		20a. Method of Di			20b. Pl	ace of Dispo:	sition (Name of natory or other pl	ace)	Date 20-2005	20c. L	ocation - City or 1	Fown, State
		23a, Part1 Enter	the disease, or compliant failure. List only or	cations that caused e cause on each li	ne.	. Do not ente	217 9th or the mode of dy		Washing ac or respiratory	ton,		0011 Approximate Interval Between Onset and Death
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To tha Hospital or Attending Ph within 24 hours after death. To tha Funeral Diractor: After thi completely filled in by the funeral	Medical (29a. Certifier (Check only one)	2 Medicel Exemir	icien: To the best ier: On the basis of and manner sta	f examinati	vledge, death on and/or inv	estigation, in my	opinion, death occ	e, and due to the curred at the time	, date an	d place, and due	to the cause(s)
Mith To Con	2	29b. Signature an		KI	~	M.D.	D	5653	1	29d. Da	ate signed (Month,	2005
10		30. Name and add Harry 31. Date filed (Ma	ress of person who co	780 Hi	ckorg	Ride	e Rd	, Coli	umbia	,	mD a	4044
St: Regist	ate rar	or, Date filed (MC	AUG 18 20	32 R egistr	ars signati	" A	all of					

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		1 - For Stata Registrar	State of Ma	C	partment of F ertificate of	Death		ene UU5 g. No.	27018
Physic /Med		Decedent's Name (First, Middle, La Sarah			Kittrell		2. Date of Death Month 8–13–2	Day Your	3. Time of Death 6: p M
Exami		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	1
		Future Care	Homewood		Bal	ltimore		NA	
Funeral Director			Sex 7. Age 1 □ M 2 🛣 F	e (In yrs. last birthda 77 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9–13	Year) 9. Birth Con	pplace (State or Foreign untry) Md.
iand in		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
e-fsh	ctor	Md.	NA	Ва	ltimore				1 XYes 2 No
3a or 28	I Dire	10e. Street and Number 539 N. Kenwoo	d Ave.		10f. Zip Code	1205	10	g. Citizen of What Cor USA	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Departiment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it a Medical Engin et installe invitified and once.	y Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🌠 N If Yes, Give	Ever in U.S. 1	3. Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2X No		pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	, etc.
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r y ro r y ro d Men d Men marke marke	2	Vachel 19a. Informant's Name/Relationship	(Time Drint)	Sherwoo		Mar	4	Camp City or Town, State, Z	
		Harry L. Steve		od-Son					
s 1 ar if Hea item;		20a. Method of Disposition		20b. Place of Dis	sposition (Name of crematory or other place			Saltimore, Oc. Location - City or 1	
Page nent o ant: #		1			Zion Cem.	´ I	18-05	Lansdowne	e, Md.
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Lice	nsee	2	22. Name and Addre	ss of Facility	Balt	imore, Md	. 21202
ECS.	07541	23a. Part1. Enter the disease, or can shock, or heart failure. List only	nplications that caused	the death. Do not	enter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		tes My	1,400				Onset and Death
/Medical Examiner		resulting in death)		a consequence of):					Civio
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e taw requir	Completed	Denestia					24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
	Com						perform	ed? death? No 1 ☐ Yes	
rician: ician: certific	Be	25. Was case referred to medical examiner?	Hospital:		Oth	00	h (Check only one		
Attending Physician: or death. ector: After this certification in the funeral director.	1: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie		tient 3 DOA	4 Nursing Ho	ome 5 Resident	ice 6 Other (Speci	(fy)
nding Phy ath. r: After thi e funeral o	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injur	y Wor	k? Yes 2 □ No		.,.,	
i or Attendation after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		ry - At home, farm, . (Specify)	street, factory, office		28f. Location (Stree City or Town,	eet and Number or Rui State)	al Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical C	29a. Certifier (Check only one)	hysician: To the best of miner: On the basis of and manner sta	examination and/or	eath occurred at the tir investigation, in my o	me, date and place, pinion, death occur	and due to the cau	use(s) and manner as and place, and due	stated. to the cause(s)
vithin To the comple	Me	29b. Signature and title of certified			29c. Licens	e number	290	d. Date signed (Month,	Day, Year)
1		13/5	1	D	Do	259052	>	8/17/05	
N		30. Name and address of person who	completed cause of de	eath (Item 23a) (Typ				0	
		31. Date filed (Month, Day, Year)	22 Rodora	r's Signature	Sparle	MT Kon	d the	Self M	10 21217
St Regist	ate trar	AUG 1 8		AC B	parte				

		riedse i	State of Maryland					_	
		1 - For State Registrar	Otato of Marytan	•	rtificate of			g. No.2 0 0 5	27019
	500	Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
Phys /Me	ician dical	Edward	Kandet	er			03 -	- 16 - 200=	5 01.00 AM
Exan		4a. Facility Name (If not institution, give s				r Location of Death	1	4c. County of Dea	
	nv.	Good Samaritan		ast hirthday)	If Under 1 Year	ltimore If Under 24 Hrs.	8 Date of Birth	1 .	A
Funer Directo		5. Social Security Number 6. Sex 1X	7. Age (In yrs. I	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, May 14,	1930 Pen	thplace (State or Foreign ountry) NSYLVANÍA
4		Usual Residence of Decedent							
anylan show	_	10a. State 10b. County	10c. City	, Town or Lo		2 4 '			10d. Inside City Limits 1X Yes 2 □ No
he Ma	Director	Maryland N/A 10e. Street and Number			10f. Zip Code	ltimore	1	0g. Citizen of What C	2.5
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland tal Hyglene. of other than "natural", or items 23a or 28a-f show event, the Medical Events art must be redified at)		Tot. Zip Godo	21206	,	u.s.	_
death ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Race - Am	erican Indian,
after or its	Fur	1 Never Married 2 Married	Armed Forces? 1 XYes 2 □ No If Yes, Give 1951-1 Year or Dates!	1053	1 ☐ Yes 2X No		o nican, etc.)	Black, Whi	
vithin 72 hours after one. than "natural", or ite	d by	3 ☑Widowed 4 □ Divorced						W	rite
n 72 I	lete	15. Decedent's Edu (Specify only highest grade	completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of wor d)	king	16b. Kind of Business	pindustry
Z Z With John Than Than Than Than Than Than Than Th	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Body	and Fend	ler Repai	rman	Automotiv	e
Iana Z ld be filed ental Hygi ked other ic evant, I	BeC						ne (First, Middle, I		
	5	Edward W. Kandeso						Rickwalte	
5 0 0 = E		19a. Informant's Name/Relationship (Ty Walter Kandefer (1			-			City or Town, State,	zıp code) yland 21044
e, R 1 and Health Iam 27		20a. Method of Disposition			osition (Name of matory or other pla			20c. Location - City o	
0 80 = 5		1 🕅 Burial 2 ☐ Cremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crei red He	matory or other pla Part of J	esus 08/19	9/2005 B	Baltimore,	Maryland
Baltim permit. Pag Department Important: any injury	ġ	21. Signature of Funeral Service License			~			Funeral Ho	
n gori	SUC	からま						e, Marykan	,
		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	cations that caused the death ne cause on each line.	n. Do not en	ter the mode of dyli	ng, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
Physicia	_	Immediate Cause (Final disease or condition resulting in death)		oske	tre lu	una (c	meer		
/Medic Examin	_	, southing in south	Due to (or as a consequ	uence of):		7			
	ē E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
cuted	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	o						1
f60, te be executed ysicien and e burial-fransit	Ä		Due to (or as a consequence	uence of):					
Hecords, P.O. Box 68/60, The law requires that the death certificate be executed the has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	dicai		d						
LI THE GEATH CERTIFICATE By the attending phy tached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date of de	elivery
be attendired for use	20	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal		□Ectopic pregnanc □ Other (s <i>pecify)</i> _	у		Month	Day Year
at the diby the staches	hvs	9 □ Unknown	9□ Unknown				T		
COTGS, P. wrequires that is been signed to should be detailed.				_		ven in Part I.	23e. Did tol		to the cause of death? Probably 4 Unknown
requi	eted	- Marvard at DI	1, 40,10	REUD	X 4-0011	(VY	24a. Was a		
Hec ne law ne law ne law se 2 s	Completed by						autops	med? prior to death?	
VITAI HECOTGS, sicien: The law requires t certificate has been signe irector, page 2 should be a	ပိ					26 Place of Dea	1 ☐ Yes		s 2 No
Of VI Physicia this cert al direct	To Be		lospital:	ER/Outpatie	nt 3□ DOA Ott	hac		ence 6 Other (Sp.	ecify)
On O ding Ph h. After th funeral			28a. Date of Injury (Month, Day Year)	28b. Time o	Wo	rk?	28d. Describe ho	ow injury occurred	
SIO tendii leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	CO. Dian of lains. Ash]Yes 2□No	286 Location (S	tract and Alumbar or C	Pura I Pauta Alumbar
DIVISION Of I or Attending Physafter death. Director: After this I in by the funeral di	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, rarm, st y)	reet, factory, office		City or Town	treet and Number or F n, State)	iurai nobie ivuiliber,
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifics completely filled in by the funeral director;) ie	29a. Certifier 1 Certifying Phy	sician: To the best of my kno						
ne Ho n 24 h he Fui	edicai	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	tion and/or in	nvestigation, in my	opinion, death occu	irred at the time, d	ate and place, and du	e to the cause(s)
To the To the Comp	2	29b. Signature and title of certifier			29c. Licen:	se number	2	9d. Date signed (Mor	
_		Uhral	~ MD			60530	1	8-16-	02
1		30. Name and address of person who of	ompleted cause of death (Iten		Print)	Bally	in, man	1 21239	
· ·	State	31. Date filed (Month, Day, Year)	32. Registrar's Signa		Carl D	1 1200 101		(~)	
	istrar	AUG 1 8 20	105 Degree -	IF M	And the state of t				

Registrar ecedent's Name (First, Middle, Last, Berneda Facility Name (If not institution, give Stella Maris cotal Security Number 6. Set. 17-24-1854 al Residence of Decedent State 10b. County Md. NA Street and Number 1600 N. Chapel Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad lementary/Secondary (0-12) 8th grade Informant's Name (First, Middle, Last) Johnie Informant's Name/Relationship (Ty) Berneda Young Method of Disposition 15 Dotter (Specify) Signature of Funeral Service Licens A Part Enter the disease, or complishock, or heart failure. List only or rediale Cause (Final base) or condition ulting in death)	Street Street 12. Was Decedent Examed Forces? 1 Yes, Give Year or Dates: ucation 26 completed) College (1-4or 5+ Douglas ype, Print) Daug	M. (In yrs. last birth 4 Yr 10c. City, Town o Bal ver in U.S. 16a. C	Timo (ay) If Under 1 Yea (b) Months Days (c) Location timore 10f. Zip Code 2. 13. Was Decedent of If Yes, specify Cu 1 Yes 2 No. 1 Yes 2 No. 1 No. No. Tuse retin 1 Ome maker 1 Ome maker 1 Ome maker 1 One Glen 1 Sposition (Name of crematory or other processed of the control of	or Location of Death Dnium r If Under 24 Hrs. S Hours Min. L213 Hispanic Origin? (Sphan, Mexican, Puerto Death) 18. Mother's Name of Worked	8. Date of Bi (Month, Di (Month,	12Day 20 4c. Cour B 5c. Cour B 6c. City or Tow B 6c. Cour B 6c. Cou	US A lace - Americalack, White, cify: B1 Business/Ir Home ame) Gee wn, State, Zij Id	place (State or Foreign ntry) Ind. 10d. Inside City Limits 1 (XYes 2 No intry? Ind. I
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ulting in death) Last		consequence of						
	d							
EMALE: b. Was decedent pregnant			аDe			23d. D	Date of deliv	rery
in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown			5 Other (specify)			ì	Month	Day Year
	ontributing to death but	t not resulting in t	ne underlying cause g	jiven in Part I.	23e. Did	tobacco use co	ontribute to t	the cause of death?
					1 🗆	Yes 2□No	3 🗌 Prol	babiy 4XIUnknown
					auto	psy	prior to co	opsy findings available ompletion of cause of
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examiner?	Hospital: 1 □ Inpatient	nt 2□EB/Quto	atient 3 DOA				ther (Speci	(v) HOCDICE
Manner of Death	28a. Date of Injury	/. 28b. Tir	ne of 28c. In	ury at ork?				HOSPICE
2 Accident investigation		***			296 Leasting	/Chronot a and \$1		- L O-uta Musaha
4 Homicide determined	building, etc.	ry - At nome, tam . <i>(Specify)</i>	. street, factory, office	3			nber or mun	ar noute Number,
	iner: On the basis of e	examination and/						
Signature and title of certifie						29d. Date sign	ned (Month,	Day, Year)
Name and address of person who co	completed cause of dea	ath (Item 23a) (T				0	113/0	
DR. TARIQ MAHMOO	OD 2300 D	ULANEY V	ALLEY RD.	TIMONIUM	, MD 21	093		
	EMALE: Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown II. Other significant conditions c	Due to (or as a d. Due to	Due to (or as a consequence of) Definition 1	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of eath (leath addeth n addeth addethen addethen addethen addethen addethen ad	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of peach octopic pregnancy Due to (or as a consequence of peach octopic pregnancy Due to (or as a consequence of peach octopic pregnancy Due to (or as a consequence of peach octopic pregnancy Due to (or as a consequence of peach octopic pregnancy Due to (or as a consequence of peach octopic pregnancy Due to (or as a consequence of peach octopic pregnancy Due to (or as a consequence of peach octopic pregnancy Due to (or as a consequence of peach octopic peach octopic peach octopic peach octop	Due to (or as a consequence of): d. EMALE: Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown 1	Due to (or as a consequence of): Due to (or as a consequence of other to (other (or an or an alogor) Due to (other to (other (or an or an alogor) Du	EMALE: Was decedent pregnant in the past 12 months? Was 2 No 23c. If yes, outcome of pregnancy 1 Live birth 2 Petal death 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23d. Date of linear 23d. Date of linear

		For	State of Ma	ryland / Depa	artment of H		•		
		Registrar 1. Decedent's Name (First, Middle,	Lant	Cei	runcate of t	Dealli	2. Date of De	Reg. No.	2702
Physicia	an		•	-			Month	Day Y	9ar 5:51 P M
/Medic Examin		4a. Facility Name (If not institution,	Wayman Levy	y, Jr.	4b. City, Town, or	Location of Death	08	07 0 4c. County of	
LXdIIIII	ei	Holy Cross Hos			Silver	Spring		Montgo	merv
Funeral		5. Social Security Number 6	. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
Director		578-72-1796	1໘M 2□F	51 Yrs.			06 23		olorado
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Maryl f sho	ō	D.C.		Washing	ton				1¾∑Yes 2 ☐ No
r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
h with		7443 8th. Stree	t N.W.		20012			USA	
deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp.	ecify Yes or No Rican, etc.)	14. Race -	American Indian, White, etc.
ore, Maryland 21215-0036 ss 1 and 2 should be filed within 72 hours after death with the Maryland by Health and Mental Hygiene. itam 27 is marked other then "natural", or items 23e or 28e-f show other traumatic avent. The Model Examinating the notified at	þ	1 ☐ Never Married 2 → Married 3 ☐ Widowed 4 ☐ Divorced		0	37	Specify:	, , , ,	Specify:	
5-0 72 hc 72 hc	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occup	during most of work	ing	16b. Kind of Busin	ness/Industry
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aryla should ind Men marka umatic	ပ	Cyrus W. Levy,		19b. Maili	ng Address (Street	-		er, City or Town, St.	ate, Zip Code)
and 2 seatth ar m 27 is nar trau		Stephanie B. Jor						n, D.C. 2	
Baltimore, Dermit. Pages 1 at Department of Hea Important: If itam any injury or otha	Ì	20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place		Date	20c. Location - Ci	ty or Town, State
		1 Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Spe			tion Ceme		9-05	Landover	, MD.
Baltimo		21. Signature of Funeral Service Li	censee	2:	2. Name and Addre	ss of FacilityMar	shall's	Funera1	Home
0 88 5 5 8		J. R ma	whall	42	17 9th. S	St. N.W.	Washing	ton, D.C.	20011
		23a. Part1 Enter the disease, or conshock, or heart failure. List or	omplications that caused nly one cause on each line	the death. Do not en e.	ter the mode of dyin	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	_a Cardion	respirator	y Failure				Onder and ocum
/Medical Examiner		resulting in death)	Due to (or as a	aconsequence of):					
	-	Sequentially list conditions,	b	consequence of:	Cancer				
d d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Coagulo				2		
. Box 68760, death certificate be executed e attending physician and of for use as the burial-transit	Еха	resulting in death) Last	Due to (or as a	consequence of):					
8760, cate be ex physician a the burial	dicai		d						
Box 68 leath certifics attending pl	Physician/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy				23d. Date of	of delivery
Box eath cer attendin for use	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at t	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	,		Month	
P.O. that the ded by the detached	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		(.), 2/				
Records, P.O. The law requires that the late been signed by the lage 2 should be detached.	by P	Part II, Other significant condition	s contributing to death bu	it not resulting in the u	inderlying cause giv	en in Part I.	23e. Did 1	obacco use contrib	ute to the cause of death?
cords w require been sig							1 🗆	Yes 2□No 3	Probably 4 Unknown
aw requires been 2 shoulk	piet						24a. Was	an 24b. We	ore autopsy findings available or to completion of cause of
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f Vital Record ysician: The law requir is certificate has been si director, page 2 should	Be (25. Was case referred to medical examiner?				26. Place of Deat			
- × · · · · · · · · · · · · · · · · · ·	2	1 Yes 2 X No		nt 2 ER/Outpatie				dence 6 Other	
	ion:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe	how injury occurred	
Division or Attanding after death. Diractor: After in by the funer	icat	2 Accident investigated and Suicide 6 Could not	t ho	Inv - At home farm st		163 2 100	28f. Location /	Street and Number	or Rural Route Number,
Division or Attanding after death. Diractor: Afte	Certification;	4 Homicide determin	building, etc	iry - At home, farm, st . (Specify)	root, tactory, omoc		City or To	wn, State)	
Divisi To the Hospital or Attan within 24 hours after deat To the Funaral Diractor: completely filled in by the		29a. Certifier 1 Certifying	Physician: To the best of	of my knowledge, deat	th occurred at the time	ne, date and place,	and due to the	cause(s) and mann	er as stated.
n 24 he Fu he Fu	edical	(Chack only 2 1) Medical E.	caminer: On the basis of and manner state		ivestigation, in my o	pinion, death occur	red at the time,	date and place, and	d due to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and tille of certifier			29c. Licens	e number		29d. Date signed (Month, Day, Year)
ř.	H.				D0062	2885		81910	
14		30. Name and address if person w						00010	
/ 1		Dr. Sonya Wych	e, M/D. 1500	O Forest G	len Rd. S	Silver Spi	ring, M	D. 20910	
Sta Registr		Dr. Sonya Wych	8 2005	r's Signature	150				
DHMH 17 Rev 1/20	_		JUL BY	Bed for for					
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 10:03AM 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE SAMARITAN 4000 BALTIMORE HOSPITAL If Under 1 Year /If Under 24 Hrs. 8. Date of Birth (Month, Day, DCC. 17, Birthplece (State or Foreign
 Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 F Yrs. 214.44-5337 Usual Residence of Decedent Maryland Director death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits worde. ital Hygiene. d other than "nature!", or items 23a or 28a-f ehov event, the Madical Examiner must be rediffed at 1 Yes 2 No Gwynn Oak Baltimore **Funeral Director** mio 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 Apt. 64 Rd. rimea 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cottege (1-4or 5+) Social Security Clerk 12th XVIS 18. Mother's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill ment of Health and Mental H tent: If Item 27 is marked ott jury or other traumatic even Be James A. Parks ena Wagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
eny Injury or other trau Sharon C. Ramos 3225 Chesterfield Ave Balto. mo 21213 20b. Place of Disposition (Name of 20a. Method of Disposition

1 ■ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State cemetery, crematory or other place! Kandelstown -05 memoral back 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
CON P. March Funeral Home P.A.
270 Freihilton Rise Balto. MD 21229 21. Signatur Funeral Price Licens Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Phrt1/ shock, Immediate Cause (Final disease or condition resulting in death) Physician CARDIO-RESPIRATORY ARREST /Medical Due to (or as a consequence of): 3-4 days Examiner SEPSIS (EPTICEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, (auron 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 20 No 1 Yes 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check only one Hospital: Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier KESIDENT 29c. License number RESCOO 1405 SANDEEP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD. RLUD, LUCH RAVEN 4000 SAMARITAN HOSPITAL JANDEEP MAGOON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 7 2005 DHMH 17 Rev 1/2001

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			_ State	State of Marylan		artment of He			ene N2 11 15	27022
	Physici		Registrer Decedent's Name (First, Middle, Last) Neal	G.		Merritt		2. Date of Death Month	Day Year 16 2005	3. Time of Death $10:40a^{M}$
	/Medic Examin		4a. Facility Name (If not institution, give st Union Memorial			4b. City, Town, or I	ocation of Death		4c. County of Death	
	Funeral Director		241-68-6713	7. Age (In yrs.)		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 10-14-	ear) 9. Birtl	nplace (State or Foreign untry) Md.
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo					10d. Inside City Limits
	or 28a-1	Director	Md. NA		Ban	timore 10f. Zip Code 21218		10g	. Citizen of What Co US A	
	hours after death with the Maryland tural', or Itams 23a or 28a-1 show at Expedient must be notified at	Funerai	The state of the s	2. Was Decedent Ever in U. Armed Forces?	S. 13.	Vas Decedent of His f Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ocify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
-0036	72 hours aft "natural; or	by	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ	1 ☐ Yes ♣☐ No If Yes, Give Year or Dates:		1 ☐ Yes X☐ No	Specify:	16	Specify: E	Black
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Maryland	should be filed vind Mental Hygie marked other tumatic event, I	To Be C	17. Father's Name (First, Middle, Last) Guy	На	argrov			(First, Middle, Ma	iden Sumame) Merrit	t
	12 sho h and 7 Is m traum		19a. Informant's Name/Relationship (Type Mary Merritt	e, Print) Wife		ng Address (Street a 2 Melville			City or Town, State, 2	tip Code)
Baltimore,	e to to		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	lace of Dispo emetery, crer	sition (Name of natory or other place)		c. Location - City or Rolesville	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License		22	Name and Address	of Facility	Baltimor		.202
D.	Pnysician /Medical		23a. Part1. Enter the disease, of complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	memsn	no not ent			r respiratory arrest	t.	Approximate Interval Between Oncet and Death
	Examiner	L	Sequentially list conditions b.	Due to (or as a consequ		7				
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8760,	cate be executed physician and the burial-transit	dicai	d.							
.O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do	death 3	Ectopic pregnancy Other (specify)	*		23d. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significent conditions conf	ributing to death but not rest	ulting in the u	nderlying cause give	n in Part I.		cco use contribute to	
Il Records,		Completed						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of 2 No
Vital	Physician; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Death			
of	ing Affey une	tlon: To	1 Yes ZNNo 10 27 Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	28c. Injury Work	at at	ne 5 ∐ Hesideno 28d. Describe how	ce 6 Other (Specinjury occurred	city)
Division	al or Attending s after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (Stree City or Town,	et and Number or Ru State)	iral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cian: To the best of my kno er: On the basis of examina and manner stated.	wiedge, deat tion and/or in	n occurred at the time vestigation, in my opi	e, date and place, a inion, death occurr	and due to the cau ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
•	To the within 2 To the complet	Ř	29b. Signature and title of confider	7 ID.		29c. License	number	290	Date signed (Monti	7, 2005
	7		30. Name and address of person who cor	lkin m.w.	333	HOW E	callent	STRA	Myac,	MalaT8
	Sta Registr		31. Date filed (Month, Dal), Year) AUG 1 8 200	32 Registrar's Signa	ture for	nti				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SAMUEL MENSAH AUGUST 2005 5:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BETHESDA

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

The Days | Hours | Min. | Jan. | 12, 11 NATIONAL INSTITUTES OF HEALTH MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Birthplece (State or Foreign Country) 1⊠M 2□F Ghana Director None Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Examinar must be notified at Director 1K Yes 2 □ No Prince Georges Laure1 with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 198 Easton St. #202 20724 Ghana filed withIn 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: δ Specify 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unemployed 12th None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental 1 and 2 should be C. K. Baffoe Hannah Cudioe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Item 27 i George Bonney-Kwofie/Friend 198 Easton St.#202 Laurel, Md. 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of He
Important: If Iter
any injury or oth 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Family Cemetery 8-31-2005 Takoradi, Ghana 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th St.N.W. Washington, DC 20011 23a. 7a/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, wock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NON-HODGKIN LYMPHOMA 8 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical The law requires that the death certificate as attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ RENAL 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 1 No Division of Vital After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification To the Hospital or Attending 5 Pending Injury 1 Natural within 24 hours after death.
To the Funeral Director: A
completely filled in by the ft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1)002345 1/2005 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

10 CENTER DRIVE, BETHESDA, MARYLAND 20892 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Dav Year FREDERICK MOORE AUG 6:00a^M JR. 10 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 241-30-4675 84 Yrs. 1921 North Carolina Director Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23s or 28e-f show the Medical Examiner must be notified at Funeral Director 1 X Yes 2 □ No D.C. Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4926 7th St. N.W. 20011 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 图 Yes 2 □ No If Yes, Give Year or Dates: 194 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1945 1946 1 ☐ Yes 2 No ģ Specify 3 ☐ Widowed 4X Divorced **Black** Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Supervisor US Printing Office permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy important: if Item 27 is marked oth any fully or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick Moore, Sr. 2 Anliza Worsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Rivers/Nephew 308 Bennington Ct. Upper Marlboro, MD. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) George Washington 8-16-2005 Adelphi, Md. 22. Name and Address of Facility
Marshall's Funeral Home, Inc.
4217 9th St. N.W. Washington, 21. Signature of Funeral Service Licensee aisha DC 20011 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) the 6 1 Yes 2 No 9□ Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 2**X** No 2 X No 1 Yes 1 Yes Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 1 Alnpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 1 XNatural 5 Pending death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funerel Direct filled in by determined 4 Homicide 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of 29c. License number 29d, Date signed (Month, Day, Year) 054347 08-14-2005 30. Name and address of p no completed cause of death (Item 23a) (Type, Print) Neerat Chopra, MD P. O. Box 83819 Gaithersburg, MD. 20883

State

31. Date filed (Month, Day, Year) Registrar



Certificate of Death

1. Decedent's Name (First, Middle, Last)

Esther May Mulcahy

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

State of Maryland / Department of Health and Mental Hygiene 2. Date of Death August 10, 2005 Year 1:55 a M 4b. City, Town, or Location of Death 4c. County of Death Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 8, 1925 9. Birthplace (State or Foreign Maryland 10d. Inside City Limits 1 Yes 2 □ No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. white Specify: 16b. Kind of Business/Industry own home 18. Mother's Name (First, Middle, Maiden Surname) Mary E. Rippeon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 2207 Brown Station Road, Upper Marlboro, Md. Date 20c. Location - City or Town, State Elkridge, Md. Schimunek Funeral Home of Bel Air, Inc. 23d. Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Date signed (Month, Day, Year)

State Registrar

0

Peter LoPresti, DO, FACP, 130 8 Business Center Way, Edgewood, MD 21040

1 Sports

PO, FACE

who completed cause of death (Item 23a) (Type, Print)

32. Raistrar's Signature

4

"AUG" 1 8 2005

H39022

Tommy Benjamin 05-05508	McConnell Jr Please 1	Type or Print in Bla	ck Indelible Ink. Ensure A	II Copies Are	Legible.
RPD	1 = For State Registrar	State of Maryland /	Department of Health and I Certificate of Death		2000 21021
	Registrar Decedent's Name (First, Middle, Last,)	Continuate of Death	2. Date of Death	3. Time of Death
Physician	Tommy B.	Mc CONNELL	Te	The second secon	5, 2005 0115 A M
/Medical Examiner	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		c. County of Death
K	Northpoint Road @		Dunda1k		Baltimore
Funeral Director	5. Social Security Number 6. Sec. 218 - 90 - 916 9	7. Age (In yrs. last I	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Usual Residence of Decedent			JUNE 1, 19	70 710
in the Marylar or 28a-f show e notified at	10a. State 10b. County	10c. City, To	wn or Location		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
vith the Mar tor 28a-fail be notified Director	10e. Street and Number	more Do	10f. Zip Code	100.0	Citizen of What Country?
> 4	8044 N	Bounday	Pd 21222	109.	11 C A
of the death viller death ville		12. Was Decedent Ever-in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - American Indian,
or its	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 Yes 2 No Specify:	o ricali, etc.)	Black, White, etc. Specify: Wh, He
15-003 72 hours a "natural", o	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	a. Decedent's Usual Occupation	166	Kind of Business/Industry
15. n. na n. na plet	(Specify only highest grad	College (1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)	rking	,
21215-00 ed within 72 ho ygiene yagiene narthan "naturant, the Medical Completed	/O	College (1-401 37)	Phimber	C	onstruction
ind tal Hy doth	17. Father's Name (First, Middle, Last)	1 1/ -	18. Mother's Nar	me (First, Middle, Maide	en Sumame)
laryland 212: 2 should be filed within and Mental Hygiene. Is marked other than surnatic event, the M. To Be Comp	19a, Informant's Name/Relationship (Ty	CONNELL , SR	b Mailing Address (Street and Alumbas or Pu	12 A. C	MINO
re, Maryland 212: 1 and 2 should be filed within feath and Mental Hygiene. Itsm 27 is marked other than other traumatic event, the M. To Be Comp	19a, momant's Namer Helationship (7)	10 - mother	9b. Mailing Address (Street and Number or Ru	+ A ha color	r or rown, State, Zip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Department of Health and Mental Hygiene, or any injury or other traumatic avent, the Medical Examples. To Be Completed by F	20a. Method of Disposition	20b. Place	of Disposition (Name of tery, crematory or other place)	Date 20c.	Location - City or Town, State
Page Page int: #	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Wiew Cremater, 8	117/05 1	Buttimore m
Balti permit. Departi importa any inju	21. Sign ture of Funeral Service Licens	A	22. Name and Address of Facility	ton Ella	seral Home, P.A.
W 80559	Late of	Leles	2134 10,11000	3pring	Rd. 21222
	shock, or heart failure. List only or	ications that caused the death. Done cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
Pnysician · /Medical	Immediate Cause (Final disease or condition resulting in death)		ES		
Examiner		Due to (or as a consequence	e or):		
The state of	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequenc	e of):		
executed in and initiansit	Cause (Disease or injury that initiated events resulting in death) Last	3			
	resulting in obality cast	Due to (or as a consequenc	e of):		
s, P.O. Box 6876C es that the death certificate beigned by the attending physicie be detached for use as the burt by Physician/Medical I		1			
Box (Bath certif attending for use as:	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delivery
O. B. ne death the atterned for for sicial	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 Ectopic pregnancy 5 Other (specify)		Month Day Year
P.O. at the d d by the elached	9 Unknown				
Division of Vital Records, P.O. Box 6876i or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physicit in by the funeral director, page 2 should be detached for use as the but the but the funeral director. Provided the physician for the page 2 should be detached for use as the but in by the funeral director.	Part II. Other significant conditions con	ntributing to death but not resulting) in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
cord * requir been s should				24a. Was an	
I Record The law requir cate has been si page 2 should				autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital idian: T certificat rector, ps	25. Was case referred to medical	Tanya Cwill	26. Place of Dea	1⊠-Yes 2□ N ath (Check only one)	lo 1⊠Yes 2□No
of Vi hysicii his cer il direct	examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/0	Other		6XXX ther (Specify) at scene
on of ding Ph After th funeral	27. Manner of Death 1 □Natural 5 □ Pending	(Month, Day Year)	Time of 28c. Injury at Work?	28d. Describe how inj	Ury occurred F TOTOKEY CLE
isio ttendi death. ctor: A y the f.	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home,	15-28 HW 1 100 5 58740	ETECTED	and Number or Rural Route Number.
Division c tai or Attending P rs after death. si Director: After t ed in by the funera Certification;	4 ☐ Homicide determined	building, etc. (Specify)	tarm, street, factory, office	City or Town, Sta	ite) -LYNHVRST RD, MD
<u>=</u> = ± € 5	29a. Certifier 1 Certifying Physical Exami	sician: To the best of my knowled	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	and due to the cause	s) and manner as stated
To the Hosp within 24 hou To the Funs completely fil	Uney .	and manner stated.	***		
To To Cor	29b. Signature and title of certifier		29c. License number		ate signed (Month, Day, Year)
	30. Name and address of person who co	ompleted cause of death (Item 22s	O.C.M.E.	Aug	gust 15, 2005
9	ANA RUBIC		l Penn Street, Baltim	ore, Maryla	and 21201
State Registrar	31. Date filed (Month, Day, Year) AUG 1 8 20	32. Registrar's Signature	Sparte		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item/3, perffl, 6846, 8/23/05 II

State of Maryland / Department of Health and Mental Hygiene

		4	For State Registrar	State of Ma	Ce	rtificate of			iene •a. ND N C	15	27020
3			Decedent's Name (First, Middle, Last	(t)				2. Date of Deat	th CU	7	3. Time of Death
	Physici /Medio		Julia F.	Moats				August :		Year 5	6:00 A M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County	of Death	
		·	Gilchrist Center 5. Social Security Number 6. S		e (In yrs. last birthday	Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Balt		
4	Funeral Director		222 20 (000	BX	93 Yrs.	Months Days	Hours Min.	(Month, Day,	Year)		place (State or Foreign htry)
	D		Usual Residence of Decedent					Jan. 12	, 1912	west	t Virginia
	the Maryland r 28a-f ahow	_	10a. State 10b. County		10c. City, Town or L	ocation				1	10d. Inside City Limits
`	8a-1.	Director	Maryland Baltimo	re	Parkvill						1 ☐ Yes 2 No
)	with ti		10e. Street and Number	_		10f. Zip Code		1	0g. Citizen of W	hat Cou	ntry?
	eath	Funeral	8820 Walther Blv	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H	dispanic Origin? (Sp.	ecify Yes or No-	USA 14. Bace	- Ameri	can Indian,
(0	r than	Fig	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📆 🕆	No		dispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black	k, White,	
03	hours after death with the ture!; or flame 23a or 28a il Exeminer must be molt	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:		ite
21215-0036	72	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Giv	edent's Usual Occup e kind of work done	during most of work	ing	16b. Kind of Bu		
121	d within giene. r then "	ldm	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Personne	1				
	be filed with tal Hygiene. d other ther event, Ibe A	ပိ	17. Father's Name (First, Middle, Last)		Mana	gement_Sp	ecialist 18. Mother's Name	e (First, Middle,)	U.S. Go Maiden Sumam		nment
an	Q 20 0	To Be	Antonio (nmr		rentino		Mary	(nmn)	Arer	•	
Maryland	2 should be and Menta is marked aumatic ev	-	19a. Informant's Name/Relationship (<u> </u>		ing Address (Street	and Number or Run	1 /			Code)
	25 E 2		Mrs. Patricia A.	Furlong -	- Daughter	1712 K I	andmark D	r., Fore	est Hill	L, M	21050
ore	of Head of itam		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place		Date	20c. Location -	City or To	own, State
Ĕ	nit. Page lartment or ortant: if injury or		4 Donation 5 Other (Specify		Bel Air	Mem. Gard	lens 8/15	5/05 I	Bel Air	, Mai	ryland
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licer	duests		2. Name and Addre	ss of Facility Messor Roa	IcComas I Id, Abino			
	\$		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused	the death. Do not er	nter the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	, ()	Afuse Co	ugece	OC Cor	morlo	na	1	Onset and Death
	/Medical Examiner		resulting in death)	Due to for as	7.7	1		9			
М	Laminer	-	Sequentially list conditions,	b. Due to (or a)	a consequence of):					_	
W	rted nsft	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence or,						
6	executed in and ial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):						
68760,	ate be hysicie the bur	Aedical		d							
	artificate ing phy e as the	Med	IF FEMALE:								
Вох	eath cer attendir for use	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	y		23d. Date Mon		ery Day Year
P.O.	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/A	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at 9∏Unknown	time of death 5	Other (specify)					34,
	es that igned b be deta	y Pt	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did tol	bacco use contr	bute to t	he cause of death?
of Vital Records,	equire en sig ould b							1 □ Ye	es 2 No	3 Prob	oably 4 Unknown
ဝ၁	faw requ as been 2 shoulk	plet						24a. Was a autops	ın 24b. V	Vere auto	ppsy findings available impletion of cause of
Œ.		Completed						perform	mn,ed?∣ d	eath?	
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	11			26. Place of Deat	h (Check only on	10)		
of	this al dii	7 2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie			4 🗆 Nursing Ho	me 5 Reside			VI Ozpece
on	ding I h. After funer	ton	1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry Year) 28b. Time Injury	Wor	rk? Yes 2 □ No	28d. Describe ho	ow injury occurre	30	
Division	Attending r death.	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At home, farm, s		103 2010	28f. Location (St	treet and Numbe	er or Run	al Route Number,
Ö	s efter	Certification:	4 Homicide determined	building, et	c. (Specify)	,,		City or Town	n, State)		•
	To the Hospital or Atterwithin 24 hours effer de To the Funerei Directo completely filled in by the	Medical (29a. Certifier (Check only one) Certifying Ph	ysicien: To the best niner: On the basis of and manner sta	of my knowledge, dea f examination and/or i	th occurred at the til nvestigation, in my o	me, date and place, opinion, death occur	and due to the cared at the time, d	ause(s) and mai late and place, a	ner as s	stated. the cause(s)
	within 2 To the comple	Me	29b. Signature and title of certifier		1 0	29c. Licens	se number	2	9d. Date signed	(Month,	Day, Year)
	/		V/ Hn	They K	US	1)-	25205	/	4090	15/	12,2005
	h		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	, Print)	11 11	00	1.00	nı	12,2005
			W. A-60	-cley 6	-7/MC		14. Clar	ice Ut	mach	1000	o eceds
	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 8 2005	32. Registra	ar's Signature	de					

Moats, Sulli 8-12-05c6: WAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Amount t Year PM Pauline Norman 2005 Emma 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death W ASH INGTON MEDICAL CENTER 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days AnneArunde ACTIMORE CLEN BURNIE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Hours Nov. 24, MD 213-01-6474 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits 10a. State 1 Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Juniper Court 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 9 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha M. Feldpusch William P. Feldpusch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Carol Musco / niece 110 Juniper Court Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 20, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation Removal from State 5 ☐ Other (Sp 2005 4 □ Donation Elkridge, MD cify) Meadowridge Memorial 21. Signature of Fureral ervice 1 Second Ave. SW 22. Name and Address of Facility M01411 Singleton Funeral Home, P.A.Glen Burnie, MD 21061 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the diseas shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final / disease or condition resulting in death) spiration Due to (or as donsequence of). mehermeri Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

Physician /Medical **Examiner**

Examiner

Physician

/Medical

MD

Director

Completed by Funeral

Be

Examiner

Funeral

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
em 27 is marked other than "natural", or items 23a or 28a-f show

If item 27

Department of Importent: If it any injury or o

/Orman

item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Mcdical Examinar must be mutified at

use as the burial-transit and attending physician õ the detached has page 2 certificate

The law requires that the death certificate be executed

or Attending Physicien:

Division of Vital Records, P.O. Box 68760

s after death. within 24 hours a

Completed by Physician/Medical Be ဥ Certification:

completely 10

Medical

State Registrar

DHMH 17 Rev 1/2001

AUG 1 8 2005

25. Was case referred to medical examiner?

1 ☐ Yes 24Z No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 THomicide

(Check only one)

29b. Signature and title of certifier

1 ₱Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Tyes

2 No

28d. Describe how injury occurred

51596

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Ambalavaner

Hospital:

5 Pending investigation

6 Could not be

determined

GlenBurnie MD 21061 103 7845 Oakwood Road

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

32. Registrar's Signature 31. Date filed (Month, Day, Year)

28a. Date of Injury (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			-	_ State	-	epartment of H Certificate of I			giene Reg. N2 0 0 S	5 27030
				Registrar 1. Decedent's Name (First, Middle, Last)			Jouin	2. Date of Dea	ath	3. Time of Death
		Physicia /Medic		Dorothy Dolores N	illes			August	14 20	005 1005 AM
		Examin	er	4a. Facility Name (If not institution, give street and number)	llam		Location of Death	46	4c. County of I	Death
		Funeral			e (In yrs. last birtl	hday) If Under 1 Year	De Gra	8. Date of Birth (Month, Day	h Yearl 9	Birthplace (State or Foreign Country)
		Director		218-50-5564	94 y	rs. Months Days	Hours Min.	Aug. 2,	1911 N	Maryland
		and w	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
		a-f sh	ţō	Maryland Harford	For	est Hill				1 ☐ Yes 2 ☐XNo
		or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	at Country?
		is 23a	eral	1708 Landmark Drive Unit E		2105		cify Yes or No-	USA 14. Race	American Indian,
	က္ဆ	after d	Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ X		13. Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, '	White, etc.
	21215-0036	ural', c	d by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify:	White
	15-	n 72 t	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of workin d)	ng	16b. Kind of Busin	ness/Industry
	212	d with	omo	Elementary/Secondary (0-12) College (1-4or :	5+)	omemaker			Own Home	e
	멀	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show summatic event, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)	_, ,		18. Mother's Name			
	Maryland	hould d Men marke maric	၉	John u/k 19a. Informant's Name/Relationship (Type, Print)	Eberhar	Mailing Address (Street	Katherin			nder ate. Zip Codel
	Z	s 1 and 2 should be filed within 72 hours after deeth with the Maryian fereight and Mental Hygiene. The fereight and Mental Hygiene a featural, or items 23a or 28a-f show titem 27 is marked other than "natural, or items 23a or 28a-f show other traumatic event, the Medical Examinar mant be notified at		Mary Mack - Daughter	1000	708 Unit E I			orest Hi	
	Baltimore,	es 1 a of Height filem		20a. Method of Disposition	20b. Place of	Disposition (Name of y, crematory or other place	D	ate	20c. Location - Cit	
	ij	Pag tment tant: i tury o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Bel Ai	ir Mem. Gard				Maryland
	Bal	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trat		21. Signature of Fundial Service Licensee		22. Name and Addre	ss of Facility Broadway S			Home, P.A. MD 21014
				23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	the death. Do n					Approximate Interval Between
		hysician		Immediate Cause (Final disease or condition	oron	A 1		ease		Onset and Death
		/Medical Examiner		resulting in death) Due to (or as	a consequence of	of):	,			> low
			Jer	Sequentially list conditions, it any, because the form of the cause. Enter Underlying Cause (Disease or injury	a consequence o	of):				
4		ecuted and transit	Examiner	that initiated events c.	a consequence of	-6\-				
,	60,	ificate be executed physician and ss the burial-transit		Dua to (of as	a consequence o	51).				
		्र का ता जाता	ledical	0.						
	Вох	eath certif attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome	2 Fetal death		,		23d. Date of	
0		he death the atten	yslci	in the past 12 months? 1 Yes 2 No 9 Unknown	time of death	5 Other (specify)				
μ	α.	w requires that the death cer been signed by the attendin should be detached for use	by Ph	Part II. Other significant conditions contributing to death t	out not resulting in	the underlying cause giv	ren in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
7	rds	requires een sign		Oldage Cutt.				1 🗆 Y	res 2 No 31	☐ Probably 4 ☐Unknown
す	()	a law ra as be a 2 sh	Completed					24a. Was autop	sy pric	ore autopsy findings available or to completion of cause of ath?
Ĵ	al F	n: The ficate I						1 Yes	3 No 1	Yes 2 No
0	X.	ysiciel s certii directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpati	ent 2 ER/Out	tpatient 3 DOA Oth	26. Place of Death ner: 4 Nursing Hor		<i>ine)</i> dence 6 □Other	(Specify)
1	n of	ng Phy fter thi	T :uc	27. Manner of Death 1 Matural 5 Pending 28a. Date of Injugence (Month, Date of Injugence)		Firme of 28c. Injury			now injury occurred	
S	Division	ttendii death. tor: A the fu	catl	2 Accident Investigation	iunt - At homo, fa		Yes 2 □No	28f Location /S	Street and Number	or Rural Route Number,
=	Div	ii or Ai after Direct d in by	Certification;		tc. (Specify)	rm, street, factory, office		City or Tow	m, State)	or Agrai Nobie Walliber,
Nilles		To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only (Ch						
		thin 24 thin 24 the F	Medi	one) and manner st		29c. Licens			29d. Date signed (/	
		E E E		I Whan r	D	D32		And this me statement	87:51	
		7		30. Name and add ss of person who completed cause of	Jeath (Item 23a) (Kim Mith	ani		
				31. Date filed (Month, Day, Year) 32. Reg	rar's Signature	of Chance	ا ۱۸ رو۰	0		
		Sta Registr		31. Date filed (Month, Day, Year) 32. Reg	ar a digitature	last.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** PORTER SR. 12:45 A^M KERDELL AUG. 13 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Heartland Health Care Center Prince Georges Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Yrs. 248-30-6328 1921 South Carolina **Director** March 25, Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d, Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or Itams 23a or 28a-f ahow traumatic event, Ita Medical Examena number to motified 1 Yes 2 □ No Directo Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 915 W St. N.W. 20001 USA 2 should be filed within 72 hours after death and Mental Hygiene. is marked other than "natural", or Itams 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2X Married 19425 1 ☐ Yes 2X No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Howard University Landscaping Supervisor 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Holiday Rivers Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 915 W St. N.W. Washington, DC 20001 Lucinda Porter/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8**-20** -2005 ^¹ 4 □ Donation 5 □ Other (Specify) Washington National Suitland, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 20011 4217 9th St.N.W. washington, D.C. Approximate interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardiorespiratory Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter U deliving Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) the ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Hypertension Be Completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 21 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attanding Injury 1 X Natural 5 Pending death. 1 Tyes 2 🗆 No investigation 2 Accident Diractor; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 15/05 D6058290 lee MD

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

4203 Queensberry Rd.

32. Registrar's Signature

Hyattsville, Md. 20781

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh Muttath, MD

AUG 1 8 2005

31. Date filed (Month, Day, Year)

		State of Maryland / De	partment of I <i>ertificate of</i>			iene _{9. N} 2. N) = '	27022		
Physician	Decedent's Name (First, Middle, Last) Bernardine Pile		orumouto or	2	Date of Death Month	Day	Year	3. Time of Death		
/Medical Examiner	4a. Fecility Neme (If not institution, give s	4b. City, Town, or Loce		4c. County		10.50				
	Sinai Hospital 5. Social Security Number 6. Sex	Baltimore If Under 24 Hrs. 8			0 Pidhala	on (State or Foreign				
Funeral Director		7. Age (In yrs. last birthd	Months Days	Hours Min.	Date of Birth (Month, Dey,			ece <i>(St</i> ate or Foreigr ry) sylvania		
*	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City, Town o	r Location					d. Inside City Limits		
or other traumatic event, the Medical Examiner must be notified at	Maryland Baltimo:		nsville					1 ☐ Yes 2 ဩ No		
Director	10e. Street end Number			10	g. Citizen of V	Whet Countr	ry?			
ia	301-A Newburg Avenu		212		USA					
by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	I3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Speci pan, Mexican, Puerto Ri Specity:	fy Yes or No- can, etc.)		e - America ck, White, e Whi	tc.		
Completed by	15. Decedent's Edu (Specify only highest grede	15. Decedent's Educetion (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry								
	12	Claim	r-Social Se			cnment				
Be	17. Fether's Name (First, Middle, Last) Joseph Smith			18. Mother's Name (10)			
2	19a. Informant's Name/Relationship (Ty	pe, Print) 19b. M	ailing Address (Street	Helei t end Number or Rural F	Shuco Route Number,		State, Zip (Code)		
any injury or other traumatic event, the Medical Examiner in once. To Be Completed by Funer	Dominick E. Piled	ggi Husband 301	l-A Newbur	g Avenue; (Catonsv	ille, N	Maryla	and 21228		
	20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State cemetery,	sposition (Name of crematory or other ple	emetery 8/		oc. Locetion - Crownsy	•			
ouce.	21. Signeture of Forteral Service Lice			ess of Facility Ashton Sch						
- a	Mak	SI-		ndson Avenu						
cian lical	23a. Pert1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.			respiretory erre	st,		Approximate Intervel Between Onset end Death		
ner .	disease or condition resulting in death)	Due to (or as a con	sequence of):					Jaars		
edical Examiner	₽ t	Myocardia	/ infarc	ction						
Exar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events	Due to (or as a con	sequence of):				1			
edical	Ceuse (Diseese or injury that initieted events resulting in deeth) Last									
Physician/Me	d	1								
should be deteched for use as leted by Physician/Mee	Part II. Other significant conditions con	tributing to death but not resulting in th	iven in Part I.	23b. Did tobacco use contribute to the ceuse of d						
by Phy			_		1 □ Ye	8 2 No	3 ☐ Probe	ably 4□Unknow		
Q.					24a. Was en perform	eutopsy led?	avei	e eutopsy findings leble prior to ipletion of cause eath?		
rector, page 2					1□ Ye	s 2 No	1 🗆	Yes 2□No		
To Be (25. Was case referred to medical axaminer?	lospital:	Ott	26. Place of Death (
- I'	12 Yes 2 No 27. Menner of Death Natural 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Day Year) 28b. Tim Injury	e of 28c. Inju	4 LINUISING HOME	d. Describe ho					
led in by the tunera Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28	f. Location (Str. City or Town,	eet and Numb State)	er or Rural	Route Number,		
<u>o</u>	00- 0-45	sicien: To the best of my knowledge, dener: On the basis of examination and/o								
oletely fil		29b. Signature and title of certifier 29c. License number								
Medical	(Check only 2 Medicel Examir	and manner stated.	22.2			d. Date signed				
completely filled in by Medical Certifi	(Check only 2 Medicel Examirone) 29b. Signature and title of certifier		22.2							
Completely filled Medical C	(Check only 2 Medicel Examir	gueria gpleted cause of death (Item 23a) (Ty	22.2							

DHMH 16 Rev 6/95

			State of Sta	of Maryland / De	•				ene .ND N N E	27000
	Physici	an	1. Decedent's Name (First, Middle, Last)	SEMARIE I	PASQUAR	TELLO		2. Date of Death Month	Day Year	G. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and nu	mber)	4b. City,	Town, or Lo	ocation of Death	August	4c. County of Dea	object of the second of the se
	Laiiiii	-	Tohns Hopkins Bayo'ia		1301	400	w6		Balton	one City
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ▼ F	7. Age (In yrs. last birth)	Months		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y-1)	ear) C	rthplace (State or Foreign ountry) ryland
	land ow		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location					10d. Inside City Limits
	ath with the Marylan 123a or 28a-f show	ctor	Md n/a	Bal	timor					1 X Yes 2 □ No
	with th	Funeral Director	10e, Street and Number		10f. Zip			10g	. Citizen of What C	ountry?
	ter death Items 23 Iner: And	neral			13. Was Dece	2122 dent of Hisp	anic Origin? (Spe Mexican, Puerto I	cify Yes or No-	USA 14. Race - Am	
36	g 5	þ	Armed F 1 Never Married 2 Married 1 Yes 1 Ves 3 Widowed 4 Divorced Year of	2 21 No	1 ☐ Yes		Specify:	rican, etc.)	Black, Whi	White
21215-0036	.72 hours "naturel", dic.1 Ext	Completed	15. Decedent's Education (Specify only highest grade completed)	(Decedent's Usua Give kind of wo	rk done dur.	on ing most of worki	ng 16	b. Kind of Business	LIEUTE
121	within ene. than "	lduc	Elementary/Secondary (0-12) College (1-4or 5+)	iite. <i>DO NOT u</i> : Homet				Home	
Dd 2	e filec othe vent,	Be C	17. Father's Name (First, Middle, Last)					(First, Middle, Ma		
Maryland	should be tind Mental I	To	Leo Pasquariello	105.4	A-SE-Add-	(0)	Sophie		Na Town Chat-	To Code)
Mar	d 2 s th ar 7 is treu		19a. Informant's Name/Relationship (Type, Print) Mr. Andrew Truffer		_				e, Md.	
Baltimore,	es 1 a of Hea fitem r othe		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from	20b. Place of D					c. Location - City o	
III III			* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	ST. St					altimor	e, Md.
Ba	permit. Departr Import. any inj.		Mobile Product 2					ral Home t Balti	e P.A. more, M	d. 21224
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final	each line.						Approximate Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death)	(or as a consequence of):					hous
U	Examiner		Sequentially list conditions, b. P.	pinoria						hous
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causes (Deceas or Highly that initiated events c.	(or as a consequence of):					
ó	be executed sician and burial-transit	Exal	resulting in death) Last C. Due to	(or as a consequence of):					
8760	cate be	dicai	d						 	
9 xo	eath certific attending p	n/Me		atcome of pregnancy	200				23d. Date of de	alivery
.O. B	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	birth 2 ☐ Fetal death nant at time of death nown	3 □Ectopic pi 5 □ Other (sp				Month	Day Year
Δ.	res that igned b	by Pł	Part II. Other significant conditions contributing to	death but not resulting in t	the underlying o	ause given	in Part I.	23e. Did tobac	oco use contribute t	to the cause of death?
ecords,	v require been sig	eted	Diabetes noilinu	N 1	1			1 Tes		robably 4 Unknown
Rec	The law ate has b page 2 si	Completed	respiratory taily	Je Vest	7/07/0	17	sorge/4	24a. Was an autopsy performe	prior to death?	
Vital		Be Co	25. Was case referred to medical examiner.	06 1000	20114	2007	6. Place of Death	(Check only one)	No 1□Ye	s 21 X No
of V	this al dii	은	Hospital L	Inpatient 2 ER/Outp			4 LI Nuising Hor	ne 5 Residence	e 6 Other (Spe	ecify)
	fune	tion	Natural 5 Pending (Moi		ury M	28c. Injury at Work? 1 □ Ye	s 2 \(\text{No} \)	ou. Describe now	injury occurred	
Division	or Attendii after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be	e of Injury - At home, fam ling, etc. (Specify)	m, street, factor	y, office		28f. Location (Stree City or Town, S		dural Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Co	29a. Certifier 12 Certifying Physician: To the (Check only one)	pasis of examination and/						
	To the within 2 To the complet	Med	29b. Signature and title of certifier	nner stated.	290	c. License n	umber	29d	. Date signed (Mon	th, Day, Year)
			Victor U	renth	X.	DO	0621	フフ	8/16/	105
	H		30. Name and address of person who completed cau	se of death (Item 23a) (T	ype, Print)	ieu	Circle	2:1301	triore	IEEIE am,
	Sta	ate	31. Date filed (Month, Day, Year) 32.	Segistrar's Signature	my.			1		
	Regist		AUG 1 8 2005	source de	Conti	•				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Net 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** RESS MINDELLE 08 05 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMULE, Por I Under 24 Hrs. 8. Date of Birth Office Days Hours Min. 0001. 13, 1930 LEVINIDALE HEBREW GER CTR BALTIMURE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country)
 MD **Funeral** Months 1 ☐ M 2 ☐ F 74 Director 212-30-9741 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir then "natural", or Items 23a or 28e-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 X No Director BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21209 7202 ROCKLAND HILLS DRIVE #109 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7. Department of Health and Mental Hygiene Important: If Item 27 is marked other then "na any injury or other treumatic event, Item Media 000.8. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME **HOMEMAKER** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LEVINE **GOLDBERG** LILLIAN HERMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7202 ROCKLAND HILLS DRIVE #109 - BALTIMORE, MD 21209 STANLEY PRESS / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MIKRO KODESH BETH ISRAEL 8/17/05 BALTIMORE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician END STAGE DEMENTIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physicien and hed for use as the burial-transit be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death P.O. I 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 TNO 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of Certification: 28d. Describe how injury occurred 1 Anatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation al or Attend after death t Director: , 2 Accident To the Hospital or Atte within 24 hours after dex To the Funeral Directo completely filled in by th 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063327 flush & wrother 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOWETHING, 2434 W. Belvedere Ane, Briting mo GIZIM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Sugar Ser J Registrar 8 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kyla Quarles 05-5430 State of Maryland / Department of Health and Mental Hygiene State Amend Item 7888Unpend Item 23a 27,28a-1 per me 6847 9-27-05 tas Registrar Certificate of Death AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Quarles Kyla August 11, 2005 11:25 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore 7. Age (In yrs. last birthday)

If Under 1 Year

If Under 24 Hrs.

Months

Days

Hours

Min.

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Months

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April 1 Age (In yrs. last birthday)

Yrs.

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April 1 Age (In yrs. last birthday)

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Min. 5. Social Security Number **Funeral** 1□M 2€F 214-73-4704 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fehow the Medical Examiner must be notified at XXYes 2 No MD Baltimore Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21205 U.S.A. 626 North Streeper Street items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ĀĀNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A NĂ None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental! Pages 1 and 2 should be Danyiello Davis Kevin Quarles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21205 item 27 626 North Streeper Street, Baltimore, Danyiello Davis-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of himportant: if its eny injury or of page. 1 Ø8urial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 8/19/05 Randallstown, 21. Sign ture of Funeral Service Licensee March Afth West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart i ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin-**Physician** Sudden Unexplained Death in Infancy (SUDI) disease or condition resulting in death /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death P.O. 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signer 2 should be d Division of Vital Records. ģ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1. Yes 2□ No certificate has t irector, pege 2 s 24a. Was an 1 XYes 2 No Hospital or Attending Physician: After this certific funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Found: within 24 hours after death.

To the Funerel Director: All completely filled in by the fu investigation 1 ☐ Yes 2 No 2 Accident 10:30 A 6 Could not be determined 3 ☐ Suicide Location (Street and Number of Rural Route Number City or Town, State) 626 N. Streeper St. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Residence Baltimore City, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ş 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 12, 2005 Ø 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 HOGAY 14 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar AUG 1 8 2005

ORIGINAL

amend 7 per F.H. g847 9/29/05 KBH

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 Year STEPHANY JULIET REGIS JULY **Physician** 25, 6:20P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner National Institutes of Health Montgomery Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 14, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2점F Months Days Hours Yrs. 40 1965 Grenada Director None Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show rthan "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 X Yes 2 □ No Director St. George Grenada 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code None Grenada P. O. Box 1227 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married ☐Yes 2 No 1 ☐ Yes 2 ☒ No Specify: Specify ģ 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Driving Instructor Self Employed hes 1 and 2 should be filed wo of Health and Mental Hygien If item 27 is marked other th or other traumatic event, IL. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Thomas Leno Felix 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once. Michael Regis/ Husband P O Box 1227 St. George, Grenada 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State Metropolitan Crematory 8-19-2005 Alexandria, VA. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Marshall's Funeral Home, Inc.
7017 Urb St. N.W. Washington, DC 20011 21. Signature of Funeral Service Libensee 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE SYMOROME RESPIRATORY DISTRESS **Physician** /Medical Due to (or as a consequence of): Examiner LYMPHOBLASTIC LEU KEMIA faut e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of): Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ₽ Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ZUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2□ No 1 ☐ Yes 2 📉 No certificate 1XYes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: the 1 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide filled 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) d title 29b. Signature a f certifier MD 00063353 MUNC 30 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892 05 €1 LAWRENCE 31. Date filed (Month D Day, Year) State 1 8 2005 Registrar

DHMH 17 Rev 1/2001

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within 72 hours after death

filed withi Hygiene.

Maryland 21215-0036

Baltimore,

certificate be executed

Box 68760,

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Division of Vital Records,

Physician:

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Hospital

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death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 State of Maryland / Department of Health and Mental Hygiene Per Dr., 6846,08/18/05dhb Certificate of Death Rag. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Rose Garner Year Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Longview Nursing Home Carroll Co. Manchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, May 26 1915 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year 1□ M 2□ F Days Jonas Ridge, NC Director 242 01 3998 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County st than "natural", or itams 23a or 28a-f shov The Medical Exact were vast be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 538 Compass Road 21220 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ited within 72 hours aftar 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☐ No Specify Baltimore, Maryland 21215-0036 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) N/A Machinist Manufacturing Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental E Be Joseph Nelson Rose <u>Annie Johnson</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1606 Auburn Court Westminster, Maryland 21157 Roger G Rose othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State August 5 2005 * 4 □Donation 5 □ Other (Specify) Gardens of Faith Cem. Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final stage **Physician** Eng disease or condition resulting in death) /Medical Due to (or as a consequence Examiner CURONNO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: Tha law raquires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Feta! death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page certificate 1 ☐ Yes No No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient - 3 DOA Certification; To After the 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 29c. License number 51705 8-2-05 Ofagos,

Registrar
DHMH 17 Rev 1/2001

State

1. Sparke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m. PANSURIYA 349 malw [Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year) AUG 1 8 2005 Westminster, mi) 21157

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on	itanding death. tor: After the funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigs		Day Year)	Injury	M	8c. Injury Work	rat Yes 2□		zou. Describe ii	ow injury	occurred		
Division	Attanding r death. sctor: After by the funer	ifica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place of I	njury - At home,	farm, str	eet, factory	, office			28f. Location (S	treet and	Number or F	Rural Route Number,	
Ö	s afte	Certification:	4 Homicide	building,	etc. (Specify)						City or Tow	n, State)			
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)	Physician: To the bes xaminer: On the basis and manner:	of examination	ige, death and/or inv	occurred a	at the tim in my of	ne, date an pinion, dea	d place, th occurr	and due to the c	ause(s) a ate and p	nd manner a lace, and du	as stated. e to the cause(s)	
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)			PVIIM	an ilun			1	m4	96	11		8	1151	05	
í	24		30. Name and address of person w	no completed cause of	death (Item 23a	a) (Type,	Print)		10:00		, 1	,	, 1	7 10	
			Sina Hospi	tal Cani	er Uns	styt.	ule	29	t// h	1. Be	Ivede	re/	tre	21215	-
	Sta Registr		31. Date filed (Month, Day, Mar)	[8 2005 ^{32, Reg}	far's Signature	A.	Space	20							

	1_ State	partment of Health and Menta	000=
	Registrar 1. Decedent's Name (First, Middle, Last)	2. Dat	e of Death
Physician	MARY ESTHER SPEAKS	A ^M ů	10 P M 15 2005 11 20 P M
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Sinai Hospital of Baltimore		N/A
Funeral	5. Social Security Number 6./Sex 7. Age (In yrs. last birthda	Months Days Hours Min. (Mo	e of Birth nth, Day, Year) 9. Birthplace (State or Foreign Country)
Director	213-26-9985 TUSual Residence of Decedent	DEC	2. 13 1926 MARYLAND
and sand	10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
h the Maryland r 28a-f ehow r notified at	MARYLAND N/A BALTIM	IORE	1 X ∑¥es 2 ☐ No
hours after death with the Maryland hours after death with the Maryland fural; or Items 23s or 28s-f show at Exeminer must be notified at ed by Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
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fler death v	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yell of Yes, specify Cuban, Mexican, Puerto Rican, 6 	s or No- etc.) 14. Race - American Indian, Black, White, etc.
by F		1 ☐ Yes 2XXIo Specify:	Specify: BLACK
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ed within 72 ho ygiene. ier than *naturi t. the Medical Completed	(Specify only highest grade completed) (Gi	ve kind of work done during most of working . DO NOT use retired)	
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should I	ANTIC CONAWAY	SARAH HENLE	
12 sh h and lis m		lling Address (Street and Number or Rural Route	
s 1 and 2 should if Health and Men item 27 is marke other traumatic	20a Method of Disposition 20b. Place of Dis	position (Name of Date	Baltimore, Maryland 21215 20c. Location - City or Town, State
Pages nent of int: If it	1XX urial 2 ☐ Cremation 3 ☐ Removal from State	rematory or other place) MEMORIAL PARK 08-22-05	
permit. Pages Department of t importent: if its any injury or of once.	21 Signary re of Funeral Service Licensee	22 Name and Address of Facility	
B a d in a d	N 1 /2 /	VILLIAM C BROWN COMMUNI 206 W NORTH AVENUE	TY FUNERAL HOME P.A.
	23a. Part1. Enter the disease, or complications that caused the death. Do not established, or heart failure. List only the cause on each line.		atory arrest, Approximate Interval Between
Physician	Immediate Cause (Final disease or condition a Pneumone	a	Onset and Death
/Medical	resulting in death) Due to (or as a consequence of):		
Examiner	Sequentially list conditions, b. Sepsis		
ed la	The to (/r as a consequence of): cause. Enter Underlying Cause (Disease or injury		
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The law requires that the death certificate be to has been signed by the attending physici cage 2 should be detached for use as the buccompleted by Physician/Medical			
eath certific attending pl	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	B⊟Ectopic pregnancy	23d. Date of delivery
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ding Physicien: The January Matter this certificate ha funeral director, page tion: To Be Com	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time	/ Work?	scribe how injury occurred
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spital cours neral filled		ath occurred at the time, date and place, and due	to the cause(s) and manner as stated.
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: Atter this certification completely filled in by the funeral director. Medical Certification: To Be C	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at th	e time, date and place, and due to the cause(s)
Withir Comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Heine Kokkam mo	RES - 000	August, 15, 2005
2	30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	altimore
State	ARUNA ROKKAM, MD S 31. Date filed (Month, Day, Year) 32. Registrar's Signature	and mospital of 18	CUTIMORE
Registrar	AUG 1 8 2005 Marine &	anai hospital of 18	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death dent's Name (First, Middle, AUGUST **Physician** 2005 02:10 /Medical 4b. City, Town, or Location of Death 4c. County of Death Name (If not institution, give street and humber) **Examiner** Saint Joseph Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In yrs. last birthday, Birthplace (State or Foreign 6. Sex **Funeral** 12 M 2□F Director Usual Residence of Decedent 10b. County 10d. Inside City Limits Town or Location 10a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director Citizen of What Country? and Numbe death with 'natural', or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status White, etc. filed within 72 hours after Hygiene. 1 Never Married 1 Yes 2/2 If Yes, Give Year or Dates: 2 No 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: λq 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (GVa kind of work done during most of working Us. DOINOTuse retired) 15. Decedent's Education (Specify only highest grade completed, permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic avent Elementary Sepondary (0-12) Be ethod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service L Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CARDIO-RESPIRATORY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cons souence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed CHRONIC RENAL FAILURE that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2XNo 1 Yes 3 Probably 4 Unknown LACTIC ACIDOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year, 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year, 29b. Signature and title of certifier 29c. License number 8-15-05 Tichre D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD LINTHICUM, M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 32. Resitrar's Signature 31. Date filed (Month, Day, Year) State AUG18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 27041 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ,200 3:10 /Medical 4b. Gity, Town. Name (If not institution, give street and number) or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country). **Funeral** 1 M 2 F Months Days 87 Hours Min. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hydene. Importent: If item 27 is marked other then "natural", or Items 23s or 28e-1 show any injury or other treumatic event, Ite Marical Examples in Milled at once. 1 ☐ Yes 2 No Director Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? -, berty Parkway 21222 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehen 8 TIN Sorte 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Thomas Shellick UN KNOWN Yary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JOHN SUDII Liberty 21222 Lewdalk 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Cause (Fine) Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** Hours disease or condition resulting in death) /Medical Due to (or as a consequence of) PNRUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2**X** No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 Inpatient 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Examiner The law requires that the death certificate be executed the burial-tran Division of Vital Records, P.O. Box 68760. use as signed by the at d be detached for page 2 s certificate After this death.

with the Maryland

Baltimore, Maryland 21215-0036

To the Hospitel or Attending Physicien: pletely filled in by the funeral after death within 24 hours a

Certification: To

29a. Certifier

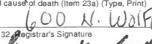
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tate Registrar

CIANG, MD torace 31. Date filed (Month, Day, Year)

AUG 1 8 2005

29b. Signature and title of certifier



and manner stated.

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29d. Date signed (Month, Day, Year) Aususz 13,200)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MARYLAND

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Month Year STECH 5-34 PETER 2005 4b. City, Town, or Location of Death 4c. County of Death HAREONS CENTER BELAIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1929 Pennsylvania Mar. 16,

10f. Zip Code

1 ☐ Yes 2 X No Specify:

21014

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Bel Air

10d. Inside City Limits

10g. Citizen of What Country?

IISA

Race - American Indian, Black, White, etc.

2005

21093

Specify: White

1 ☐ Yes 2 ☐ No

For State Registre 1. Decedent's Name (First, Middle, Last) **Physician** SHOL /Medical 4a. Facility Name (If not institution, give street and number) Examiner UPPER CHESAPEAKE MEDILAL 5. Social Security Number **Funeral** 1 🔀 M 2 🗆 F 76 180-22-0962 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b Counts or 28e-f show th and Mental Hygiene. ?7 is marked other then "neturel", or liems 23e or 28e-f shov treumetic event, tre Maxical Examiner trust be natified at Maryland Harford Directo 10e. Street and Number 127 Regent Drive filed within 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Tyyes 2 □ No Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hient: If item 27 Is marked oth Be Peter (NMN) Stech 2 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 Is any injury or other tree once. Mrs. Joan W. Stech/Wife 20a. Method of Disposition 1 😾 Burial 2 ☐ Cremation 3 ☐ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify) of Funderal Service Licensee Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit and Box 68760 Physician/Medical use as the IF FEMALE 23b. Was decedent pregnant in the past 12 months? for ed by the a P.O. 9 Unknown signed to Division of Vital Records, þ ARETES Completed has page 2 certificate Hospitel or Attending Physicien: director. 25. Was case referred to medical Be examiner Hospital: 1 | Inpatient 1⊈¥es 2□No 2 this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death Certification: After 5 Pending investigation death. 2 Accident Director: 6 Could not be 3 🗌 Suicide

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Steel Manufacturer Millwright Foreman 18. Mother's Name (First, Middle, Maiden Surname) Anna (NMN) Sirko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21014 127 Regent Drive, Bel Air, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 8-15-2005 Darlington, MD Darlington Cemetery 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the teeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death HADOUD Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown MELLINS 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 242 No 1 ☐ Yes 20 No 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 RP/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Tyes 2 No Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Funerel hours

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> State Registrar

AUG 1 8 2005

SPNASHU

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Julian C Stavley 5:37M **Physician** 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 ₹ M 2 □ F Director July 9, 1918 255-42**-**0435 Georgia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County or 28a-f show other traumatic event, the Medical Exercicer must be notified at 1 ☐ Yes 2√ No Director MD Columbia Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a Completed by Funeral 5400 Vantage Point Road #608 21044 death Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. and I file marked other than "natural; or file and the marked other than "natural; or lite ury or other traumatic event, It at Medical Exertinal ury or other traumatic event, It at Medical Exertina 1 Yes 2 No 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates: 142-45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coffege (1-4or 5+) 12 professor college 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Julian Cecil Stanley Sr Ethel May Cheney 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Stanley/spouse 5400 Vantage Point Road #608 Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department Important: If any injury or ^¹ 4 ∑Donation 5 □ Other (Specify) Funeral Service Licensee S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final KB3 PIRATORY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any leading to mediate cause. Enter Underlying Cause (Disease or injury Examiner Now Hoo gland Lymphona The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year jo in the past 12 months? 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 🔀 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c License number 29d, Date signed (Month, Dey, Year) 29b. Signature and title of certifie 22856 mof/2, 2005 a, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Little / 154xer they 11055 Vecen I. Levise, 20 (olcusous) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 1 8 2005

			1 - For State of Maryland / Department of Certificate		ental Hygier	0000 00011
	Physici		Decedent's Name (First, Middle, Last) RONALD SMITH		2. Date of Death	3. Time of Death 7 • 3 0 7 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, To	wn, or Location of Death TIMORE		2005 4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1.	Year If Under 24 Hrs. 8 Days Hours Min.	B. Date of Birth (Month, Day, Ye.	ar) 9. Birthplace (State or Foreign Country)
	aryland show	J.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 □ ¥es 2 □ No
	vith the M r or 28a-f be notifie	Directo	MD • N/A BALTIMORE 10e. Street and Number 10f. Zip Co	ode	10g.	Citizen of What Country?
36	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or items 23a or 28a-f show event. The Mcdral Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes, Sive	21213 It of Hispanic Origin? (Specir Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	within 72 hou lene. than "natura the Mcdical E	Completed I	15. Decedent's Education 16a. Decedent's Usual C	done durina most of working	9	. Kind of Business/Industry
land 2	should be filed of Mental Hygie marked other	To Be Co	12TH 17. Father's Name (First, Middle, Last) RAYMOND SMITH	18. Mother's Name (
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic			Street and Number or Rural Communication Ave BALTI		ty or Town, State, Zip Code)
Baltimore,			20a. Method of Disposition 1 Burial 2 CCremation 3 Removal from State 4 Donardon 5 Other (Specify) 20b. Place of Disposition (Name cemetery, crematory or other	er place)		BALTIMORE, MD
Balt	permit. Page Department of Important: If any injury or once.		21. Sign for Funeral Service Licensee 22. Name and CALVIN 1412 F.	Address of Facility B. SCRUGGS PRESTON	S FUNERA	AL HOME
	Pnysician /Medical	S 0	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		respiratory arrest,	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	licai Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
.O. Box 6	the death certific by the attending p ached for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (special pregnant at time)			23d. Date of delivery Month Day Year
rds, P	es tha gned be del	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	se given in Part I.	23e. Did tobace	co use contribute to the cause of death? 2 No 3 Probably 4 Munknown
Il Records,	The ate his page	Completed			24a. Was an autopsy performed 1 Yes 2	
Vital	Physician: The this certificate ral director, pages	o Be	25. Was case referred to medical examiner? 1 Yes	Other: 4 Polyursing Hom		a 6 ☐ Other (Specify)
of	ding After fune	l⊢:		4 E Nuising Flori	8d. Describe how i	
Division	- 9 - 7	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	office 28	8f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	n my opinion, death occurred	d at the time, date	and place, and due to the cause(s)
	To the within 2 To the comple	Σ		COE1789		Date signed (Month, Day, Year) GUST 15 2005
	\		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lokkanne Ofoki Awuah, 5501 Luch Rav			
ì	∍ Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 1 7 ZUUD 32. Registrar's Signature			

DHMH 17 Rev 1/2001

State Registrar

AUG 1

7 2005

11			For	State of Maryl	and / Depa	artment of	Health a	ind Mental Hy	giene	
		-	For State Registrar			rtificate of			Reg. N2 0 0	5 27046
	Physicia		1. Decedent's Name (First, Middle, La	st)	Thomas	ac		2. Date of De Month	Day Ye	3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution, giv	street and number)	Thom	4b. Cily, Town,	or Location o	August	14, 2005 4c. County of I	4:09 P M
	Examin	er	St. Agnes Hospit			Baltim		, 504	, and a second of	NA
	Funeral	1	Social Security Number 6. S	ex , 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	r If Under	Min. 8. Date of Bir	rth 9.	Birthplace (State or Foreign Country)
	Director	Ċ	218- 28-9645 Usuel Residence of Decedent	□M 212F	10 Yrs.			April 1	1, 1932 N	Carolina
	yland sow		10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f et	ctor	MD NIA	4	Baltimo	re				1 Yes 2 No
	72 hours after death with the Maryland natural; or items 23s or 28s-f ehow lical Examinar must be notified at	by Funeral Director	10e. Street and Number	01		10f. Zip Code	6		10g. Citizen of Wha	it Country?
	Seath of	erai	500 Roundvieu	12. Was Decedent Ever	in U.S. 13.	Was Decedent of	Hispanic Orig	gin? (Specify Yes or No		American Indian,
9	after or iter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cu 1 ☐ Yes 2 ☐ No		, Puerto Rican, etc.)	Specify: A	White, etc.
215-0036	hours urai',		3 Widowed 4 □ Divorced	Year or Dates:						DIUCK
-5	in 72 in 72 in mat	plete	15. Decedent's E (Specify only highest gr	de completed)	(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most	of working	16b. Kind of Busin	ess/industry
212	d within giene. er then *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Secui	rity			Housing,	Authority
	be file tal Hy d oth event,	Be	17. Father's Name (First, Middle, Last			•	Mah	r's Name (First, Middle	, Maiden Surname)	,
Maryland	hould d Men marke matic	၉	19a. Informant's Name/Relationship (Tuna Printl	19h Maili	na Addraes (Strae		or or Rural Route Number	naer Der City or Town Sta	ate. Zin Code)
S	tth and 2 si		St. 1	is - 50n	500	Round	4	- 1 1 11		
Je,	ss 1 ar		20a. Method of Disposition	20	b. Place of Dispo cemetery, cre		1	Date	20c. Location - Cit	
Ē	Page ment c ant: if ury or		1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		MT- Z	2000	en!	19-05	lansa	rune, md,
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merital Hygiene. Department of Health and Merital Hygiene "natural", or itema 23a or 28a-1 show montant: if item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other traumatic event, the Marical Examinar must be notified at once.		21. Signature of Fineral Service Lice	300	S	2. Name and Add ATV Fred 40 Fred	ress of Facility	Funeral H	OF PAS	21229
п			23a. Parti. Enter the disease, or com shock or heart failure. List only	plications that caused the cone cause on each line.	death. Do not en	ter the mode of dy	ring, such as	cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Lause (Final disease of condition resulting in death)	a. Hyperthern		plicative	ather	osclewsicc	udicrasa	
	Examiner			Dule to (or as a cor	nsequence of):	all sea	se.			
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	sequence of):					
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	and an analysis of his					
760,	eath certificete be executed ettending physicien and for use as the burial-transit	cai E	l	Due to (or as a cor	isequence or).					
89	uficete g phys as the			0.						
Вох	death certifice e ettending ph id for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pro		⊒Ectopic pregnan	су		23d. Date of	f delivery Day Year
0.	he des	ysic	1 Yes 2 No	4☐ Pregnant at time 9☐ Unknown	of death 5[Other (specify)				-
<u>a</u>	w requires that the de been signed by the s should be detached	y Ph	Part II. Other significant conditions	contributing to death but no	t resulting in the u	inderlying cause g	iven in Part I.	23e. Did	tobacco use contribu	ite to the cause of death?
ords	equire en sig ould b	ted b						1_	Yes 2 0 3	☐ Probably 4 ☐ Unknown
Records,	e far hes	Completed							opsy prio ormed? dea	
_	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place	1 ☐ Yes of Death (Check only	~	Yes 2 □ No
of Vital	hysicl his ce I direc	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 XER/Outpatie	nt 3□ DOA C	ther: 4 ☐ Nu	rsing Home 5 ☐ Res	idence 6 Other	(Specify)
o uc	ling P	ion:	27. Mann of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	W	uryat ork? ⊒Yes 2.027	الأميانية	how injury occurred	devited
Division	Attency death ctor:	ficat	2 Accident investigation 3 Suicide 6 Could not to determined	e 28e. Place of Injury -	At home, farm, st	P M 1[reet, factory, office		28f. Location	(Street and Number	or Rural Route Number,
S	al or / s after of Dire	Certification:	4 Homicide	building, etc. (S)	oecify) i			City or To	iwn, State) tow man Ave	, Beltmore (MD)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier 1 Certifying Pl (Check only one) 1 Medical Exa	nysician: To the best of my niner: On the basis of examiner stated.	knowledge, dea	th occurred at the ovestigation, in my	time, date an opinion, dea	d place, and due to the	cause(s) and mann	er as stated.
	To th To th comp	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (/	Month, Day, Year)
			Joist of	Te enf M	0	OCI	Æ		August 15	, 2005
	3		30. Name and address of person who	1	(Item 23a) (Type		G :		G	
	Sta	te	31. Date filed (Month, Day, Year)	Deva M.D. 3e. Registrar's S	ignature	111 Per	m Stre	eet, Baltim	ore, Mary	Tand 71401
	Registr		A116.1.7.744		Il doa	de				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#31, per DVR, C846, 8/18/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yeer Physician 10 PM Cobert luatson tagust 16, 2005 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Good Samaritan Hospital Baltimore NA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1X M 2☐ F 5. Social Security Number **Funeral** Months Yrs. 4-27-29 253-42-1408 76 Ga Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show ral', or Items 23a or 28a-f shov Exerciser must be notified at YOY 2 No Md. NA Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1125 E. Belvedere Ave. 21239 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 【 ☐ No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural; or Item any injury or other traumatic event. In a Medical Environment 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Self-Employed Tracker Trailer Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES WATSON JENNIE YANCY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21239 Hannah Watson Wife 1125 E. Belvedere Ave. Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 20a, Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) King Mem. Park 8-20-05 Randallstown, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Cicensee 21202 Baltimore, Md. 1101 E. North Ave. March F.H. East 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) pars /Medical quence of): Due to (or as a cons **Examiner** 410 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medlcal the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year detached for 4☐Pregnant at time of death 5 Other (specify) the 9□ Unknown 9 Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has page 2 autopsy performed? 1 Yes 1 Tyes 2 40 2 No Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ♥ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 29 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending s after dea. - of Director: After 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeref D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 17, 2005 DOO 55 583 UB Shot Lock Naven Blad. Boltomore Us 21239 30. Name and address of person who completed cause of death (Item 23a) (Type, Print))avid Namar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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2005

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		1 - State Registrar	ite of Maryland / Depa Cer	artment of Health and N tificate of Death	lental Hygier	2005 2	27048
OL		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medic		MARIE	W	ASHINGTON	_	8 2005	1200 PM
Examin		4a. Facility Name (If not institution, give street a 1030 Comet Street	and number)	4b. City, Town, or Location of Death Baltimore		4c. County of Death N A	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yei 6-14-1	ar) Count	ace (State or Foreign try) M.d.
and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		10	Od. Inside City Limits
daryli f sho	ō	Md. NA	Ва	ltimore			1 ⊈Wes 2 □ No
ith the Marylar or 28a-f show e notified at	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Count	iry?
3a or	<u></u>	1030 Comet Street		21202		USA	
is 1 and 2 should be filed within 72 hours after death with the Maryland if Healint and Mental Hygiene. If Healint and Mental Hygiene. Other traumatic event, the Medical Examinar must be notified at	by Funeral	1 Never Married 2 Married 1	TYPS 2 TANO	Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2 ♣ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	atc.
hours stural,		3 AWidowed 4 □ Divorced Ye 15. Decedent's Education	par or Dates:	lent's Usual Occupation	16b	Specify: B Kind of Business/Ind	lack
nin 72	Completed	(Specify only highest grade comp	oleted) (Give life. E	kind of work done during most of work DO NOT use retired)	ing		
d with giene er the	mo.	9th grade	Do:	mestic		Other Peop	le Homes
2 should be filed within and Mental Hygiene. Is marked other than aumetic event, the Mental county.	To Be (17. Father's Name (First, Middle, Last) Mack	Riley		e (First, Middle, Maid .nnie	len Sumame)	
		19a. Informant's Name/Relationship (Type, Pr		g Address (Street and Number or Rur Twin Oak Rd.,			Code) 28146
C, IV T and Health em 27 ther tr		Michael Washington 20a. Method of Disposition	20b. Place of Dispos	sition (Name of		Location - City or Tov	
Pages nent of I		1 ☐ Burial 2 □ Cremation 3 □ Remove 1 □ Donation 5 □ Other (Specify)		Bapt. Ch Cem.		ranite Qu	
partitions, we permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		21. Signature of Funeral Service Licensee	22.	Name and Address of Facility March F.H. East		more, Md. E. North	21202
		23a. Part 1. Enter the disease, or computation shock, or heart failure. List on the cau	s that caused the death. Do not ente				Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		TIC CANDIOVASO			Onset and Death
/Medical Examiner			Due to (or as a consequence of):				
д . I	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
cate be executed physician and the burial-transit	Examiner	that initiated events c.	Due to (or as a consequence of):				
e be e	dical E	d					
tifficat ng phy as th	Medi						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Hotel this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	Day Year
w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributi	ng to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
equire equire ould b	ted t		ECPS 15		1 🗆 Yes	2 No 3 Proba	ably 4 Minknown
vital nack iician: The law r certificate has be rector, page 2 sh	Completed	K	OFINATORY FAI	Line	24a. Was an autopsy performed	death?	nsy findings available inpletion of cause of
ian: artifica ctor, p	BeC	25. Was case referred to medical examiner?		26. Place of Deat	n (Check only one)		
hysic his ce	10	1 ☐ Yes 2 ☐ No Hospita	ll: 1 ☐ Inpatient 2 ☐ ER/Outpatient	t 3 DOA Other: 4 Nursing Ho		6 ther (Specify,	HOSPICE
ding P h. After t	tlon:	1 Latural 5 Pending	a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	N/A	
r Atten er deat rector: by the	Certification:	- To a see of Could not be	a. Place of Injury - At home, farm, stre building, etc. (Specify)		28f. Location (Street City or Town, Str	and Number or Rural ate)	Route Number,
urs afte			/	VA		NIA	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Examiner: 0	 To the best of my knowledge, death in the basis of examination and/or inv nd manner stated. 	occurred at the time, date and place, restigation, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as sta and place, and due to	ited. the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month, D	ay, Year)
(B	ANBANA C. SUN.	100 MD D5757	/	8/9/05	
X							
Sta		31. Date filed (Month, Day, Year)	BANBANA Co	all s			
Registr	ar	AUG 1 8 2002	ADRIVED IN THESE				

			1 - For State Registrar	State of I	Marylan	-	rtmen <i>tificat</i>			and M		giene Reg. NØ	105	27010
	Physici		Decedent's Name (First, Middle, L.	Gwend	o1yn	0. W	arren	1			2. Date of Dea Month		Year 2005	3. Time of Deam 6:00 Р. м
	/Medio Examin		4a. Facility Name (If not institution, gi		er)			Town, or	Location o	of Death		-	unty of Death	1
	Funeral Director			Sex 7. 1 □ M 2 💢 F	Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day 11-28	h y, Year) 8–1940	Cot	nplace (State or Foreign untry) Md
	e Maryland ie-f show	ctor	10a. State 10b. County N/	A		, Town or Lo Balto	cation							10d. Inside City Limits 1 Yes 2 No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel; or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at ODGe.	by Funeral Director	10e. Street and Number 5032 Carmine Ave 11. Marital Status 1 Never Married 2 Married 32 Widowed 4 Divorced	12. Was Decede Armed Forci 1 XYes 2 If Yes, Give Year or Date	es? □ No	ĺ	Vas Deced	2120 dent of His	spanic Orio	gin? (Spe , Puerto I	ocify Yes or No- Rican, etc.)	U S	A Race - Amer Black, White	ican Indian, s, etc.
Baltimore, Maryland 21215-0036	iled within 72 ho Hygiene. ther then "neture nt, the Wedical I	Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Las	ade completed) College (1-4 N/A	or 5+)	life. L	lent's Usua kind of wor DO NOT us urity	of f Of f	icer		ng (First, Middle,	Stop		ndustry ity Agency
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Baltin	permit. Po Depertme Importent any injury		21. Signature of Funeral Service Lice		Aro	outus M			s of Facility	у Ма	rch F/F Avenue	H Wes		1 21215
	Physician parameter physician and physician and physician and physician and physician	Examiner	23a. Part1. Enter the disease, or corshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (h line.	n. Do not enter Stive Juence of): Lucation					rest,		Approximate Interval Between Onset and Death	
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	Registr	ar	AUC 1 8 3	005	a	H. Go	are							

05-05480 Steven Wentz

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3	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last Steven R. Wentz Aa. Facility Name (If not institution, give University Hospita	street and number)		4b. City, Town, or		2. Date of Death Month August	Day Ye 13, 20 4c. County of I	aar 3. Time of Death 005 20:44 M Death ore City
	Funeral Director		5. Social Security Number 6. Se			If Under 1 Year Months Days	timore If Under 24 Hrs Hours Min.		Year) 9.	Birthplace (State or Foreign Country) MD
A contract of the state of the	a or 28a-f ehow	Funeral Director	10a. State 10b. County MD Anne Aru 10e. Street and Number		Fown or Loca	10f. Zip Code			g. Citizen of Wha	10d. Inside City Limits 1 □ Yes 2√ No at Country?
ocoo	If Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, I'm Medical Exeminar must be notified at	by	8342 New Cut Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2₹ No If Yes, Give Year or Dates:	1[Yes 2DXNo	Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. White
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yland	Mental Hy narked oth natic event	To Be	17. Father's Name (First, Middle, Last) Robert J. Wentz				Carolyr			
e, mar	Health and		19a. Informant's Name/Relationship (T) Ms. Carolyn Wentz 20a. Method of Disposition	/ Mother	231 0	ld Magot	hy Bridg	ge Rd, Pas		MD 21122
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requires the	should be det	þ	Part II. Other significant conditions con	ntributing to death but not resultin	ng in the und	erlying cause grve	n in Part I.	23e. Did toba 1 ☐ Yes	/	te to the cause of death? Probably 4 □Unknown
an: The law	death. tor: After this certificete hes t the funeral director, page 2 s	e Completed	25. Was case referred to medical				26 Pines of Doc	24a. Was an autopsy performe Yes 2 [ath (Check only one)	prior	e autopsy findings available to completion of cause of b? Yes 2 No
hvaici	his cer Il direc	To B	1A 163 2 140	lospital: 1 X Inpatient 2 ☐ ER/	/Outpatient	Otho	-	lome 5 Residen	ce 6 □Other (5	Specify)
To the Hospital or Attending Physician:	within 24 hours efter death. To the Funerel Director: After is completely filled in by the funere	Certification:	27. Manner of Death 1 Netural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)		t, factory, office	es 2 No	City of Town,	COLIDO et and Number of State)	7 WITH CAS R
he Hospite	within 24 hours effer of the Funeral Directompletely filled in by	edical	29a. Certifier 1 Certifying Physics (Check only one)	sician: To the best of my knowled her: On the basis of examination and manner stated.	dge, death o	courred at the time	e date and place	and due to the cau	so(s) and manna	ras stated. due to the cause(s)
10	1	Σ	29b. Signature and title of certifier	While Ms			number		Date signed (M Sust 14	
	φ Sta		30. Name and address of person who compared to the state of the state	32 Registrar's Signature	l Penn		Baltimo	ore, Maryl	and 2120	01
	Registr	ar	` ΔUG 1 & 2005	Esc. M	A.a.	1.				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 13, Month 2005 Ε. **Physician** Vernon Warehime 4:11 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/AUnion Memorial Hospital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 16,1929 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☑ M 2 ☐ F 220-22-1658 76 Maryland Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Medical Examinat must be notified at N/ABaltimore 14 Yes 2 No Maryland Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 3515 Buena Vista Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 茶粒yes 2□No If Yes, Give Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, the Medic 2005. Elementary/Secondary (0-12) College (1-4or 5+) Lever Brothers Reactor Operator 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Catherine R. Singer Alfred J. T. Warehime 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3515 Buena Vista Avenue Baltimore, MD Dorothy L. Warehime Wife 21211 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Memorial Date 20a. Method of Disposition 20c. Location - City or Town, State 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State 8/18/05 Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Koad Baltimore, Maryland 21211 art . Enter the . . ea e, or complications that caused the death, shock, or heart indure. List only in a cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Po Day Month Year in the past 12 months? 4□Pregnant at time ol death 5 Other (specify) ☐Yes 2☐No should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 1 Mo 1 Inpatient Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this uneral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 DNatural 5 Pendina investigation 1 Tes 2 🗆 No 2 Accident filled in by the 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Nedicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature an License number who completed cause of death (Item 23a) (Type, Print) MERLA 121. Linta 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Patient known as James Wilson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No? 2. Date of Death Decedent's Name (First, Middle, Last) Year **Physician** 52 August James Wilson 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 00 Baltimore Daltimore Hospital If Under 1 Year If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 10XM 2□F Yrs 09-12-1913 North Carolin 241-26-9477 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location YYYes 2 □ No Funeral Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4728 Wakefield Road, Apt.201 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify African-1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2nd Assembly Maintence General Motors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) in and 2 should be fill Health and Mental H tam 27 is markad oth Sophia Little John Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If of Health 20b. Place of Disposition (Name of cemetery, crematory or other place)

Street, 311 Street, 321218 20c. Location - City or Town, State Charles Wilson Sr./Son permit. Pages 1
Department of Hi
Important: If itan
any injury or oth 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) National 8-23-05 Laurel, MD 21. Signa Mar Funeral Arvice Ligensee 22. Name and Address of Facility Wylie F/H P.A.of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 Part1. Enter the disease, or com shock, of heart allure. List only that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Theomonia Assiration Pnysician /Medical Due to (or as a consequence of): **Examiner** Renal Failure Acute Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy performed? 2 3 NO 2 -NO 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 Ho 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funaral C factifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital Cohen

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

8 2005

ORIGINAL

32 égistrar's Signature

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5.0	2	Decedent's Name (First, Middle, Last)					2. Date of De Month		Yeer	3. Time of Death
Physici /Medic	0.00	Ernest Wright					JULY	22,	2005	8:37P. M
Examin		4a. Facility Name (If not institution, give street and nu	mber)			Location of Death			ounty of Death	
		NORTHWEST HOSPITAL 5. Social Security Number 11nk 6. Sex	7. Age (In yrs. I	ast hirthday)	RANDALLS'I		8. Date of Bir	th	LTIMORE 9. Birtho	place (State or Foreign
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28a-i	Director	MD 10e. Street and Number	De	i I C I III O	10f. Zip Code			10g. Citize	n of What Cou	ntry?
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Page Page nent c		1 □ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 🖫 Other <i>(Specify)</i> in st	State							
Dalitimor permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee Ronald S. Wade	birector	2	2. Name and Address State Ana	ss of Facility tomy Boar	d 655 W	. Bal	timore	Street
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		shock or heart failure. List only one cause on Immediate Cause (Final	each line.					1		Interval Between Onset and Death
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To the within To the	Σ	29b. Signature and title of certifier	(3	1	29c. Licens	e number CME			signed (Month,	
		I arde Hal	lan	ma				JULY	23, 20)U5
		30. Name and address of person who completed call	use of death (Item	n 23a) (Type	, Print) 111 Pc	enn Street	t Ralt	imore	Maru1	and 21201
Tell on least Co	ate	31. Date filed (Month, Day, Year) 32.	Registrar's Signa	ature		DOLCO		LINOTE	, inty	∠12U1
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7	Examir	ner	4a. Fecility Name (If not institution,)		4b. City, Town, or L	ocation of Death	4c. County					
			Manor Care Who				Wheaton	· · · · · · · · · · · · · · · · · · ·		gomen				
	Funeral Director		5. Social Security Number 579-66-4645 Usual Residence of Decedent	. Sex 7. A 1 ☐ M 2 ☑ F	ge (In yrs. lest birt	hday) if Under 1 Yea Months Day		8. Date of Birth (Month, Day 10 12	Year) 49		lace (State or Foreign try) ngton, D.C			
	irylend show	١	10a. State 10b. County		10c. City, Town			·-		10	Od. Inside City Limits			
	the Ma 28a-1 s	ecto	D • C •		wasn	ington 10f. Zip Code			l0g. Citizen of V	Whet Coun	1X Yes 2 No			
	th with	al Dir	612 Van Buren	Street N.W		200			USA					
020	be filed within 72 hours after death with the Marylend that Hygiene. do other then "netural", or tlems 23a or 28a-f show event, the Medical Exerting roust be truffled at	by Funeral Director	11. Maritel Status 1☑ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?	13. Was Decedent of If Yes, specify Cu		pecify Yes or No- Rican, etc.)	Blac	e - Americ k, White, Blac	etc.			
5-0	72 ho netur	eted	15. Decedent's (Specify only highest)		16e.	Decedent's Usual Occ	upation e during most of wor	kina	16b. Kind of Bu	siness/Inc	lustry			
Maryland 21215-0020	within ene. then	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of work don life. DO NOT use reti		9	U.S.	Couer	nment			
D	e filed withi al Hygiene. other then vent, the M	Be Co	17. Father's Name (First, Middle, La	2 yrs.		Secretar		ne (First, Middle, i			imeric			
<u>lan</u>	should be nd Mental marked o	To B	JOseph J. Will	iams			Ella Cı	cockett						
ary	s and a series		19a. Informant's Name/Relationship	(Type, Print)		Mailing Address (Stre								
Σ.	es 1 end 2 of Health a item 27 is r other tre		Ella Williams/N	lother		2 Van Bure		. Washin	gton, D	.C. 2	:0011			
Baltimore,	Peges 1 end nent of Healt unt: If item 2 ury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		9	Disposition (Neme of y, cremetory or other prood Cemete		Date 08-16-05	20c. Location - Washin					
Balt	permit. Pege Department of Important: If any Injury or once.		21. Signature of Funeral Service Lie	tensee			ress of Facility Man							
	_		23a. Pert / Enter the disease, or co shock, or heart feilure. List or	emplications that cause ly one ceuse on eech	ed the death. Do n	ot enter the mode of d	ying, such as cardiac	or respiretory arr	est,		Approximate Interval Between			
- distant	Physician /Medical		Onset and D											
1	Examiner		disease or condition resulting in death)	e						1	Month			
P		je		Amrr 1	Due to (or as e o	onsequence or):					months			
V	cuted nd ransit	Examiner	Sequentially list conditions.	b. Allly I	oidosis	viisequence vI).			-	montins				
Ö,	e exe		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Mult	iple Mye	1oma				8	months.			
x 68760,	certificate be executed anding physician and use as the buriel-transit	√/Medicai	that initiated events resulting in death) Last	that initiated events										
O. Box	death e ette ed for	Physician/	Part II. Other eignificant conditions	contributing to death	but not resulting in	the underlying ceuse	given in Part I.	23b. Did to	obacco uee con	tribute to	the cause of death?			
P.O.	thet the	by Ph	Vancomycin r	esistant e	nterogen	ous in the	stool	1□ Y	ee 2⊡No	3 Prob	ably 4 ⊠ Unknown			
Records,	law requires thet the as been signed by th s 2 should be deteche	Completed b						24a. Was a perfori	n autopsy med?	ava	ere autopsy findings allable prior to appletion of cause death?			
æ	9 - 6	E O						1□ Y	es 2 No	1 🗆]Yes 2□No			
Vital	ysicien: The is certificate director, par	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th <i>(Check only on</i>	re)					
o {	S 0 0	2	1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Out	petient 3 DOA	other: 4₺ Nursing H	ome 5 🗆 Reside	ence 6 □Othe	er (Specify)			
ion	ling After fune	ation:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigat		ury ey Year) 28b. T	ijury W	ury at ork? □ Yes 2 □ No	28d. Describe ho	ow injury occurr	ed				
Division	ai or Attends efter deetheid bi Director:.	Certification:	3 Suicide 6 Could no determine	ad 286. Place of It	njury - At home, far tc. (Specify)	m, street, factory, offic	Э	28f. Location (St City or Town		er or Rura	Route Number,			
	To the Hospital or Att within 24 hours efter d To the Funerel Direct completely filled in by	edical (Phyeiclan: To the best aminer: On the basis of and manner s	of examination and									
	To the within 2 To the comple	M	29b. Signature and title of certifier	solla-d	1 Qua		nse number 0057630	2	9d. Date signed 8-11-0		Jay, Year)			
	6		30. Name and address of person who Dr. Anuradha A		deeth (Item 23e) (Type, Print)	#209 Sil	ver Spri	ng, MD	2090	2			
	Sta	te	31. Date filed (Month, Day, Year)		har's Signature			-1	<u> </u>					
	Registr		AUG 1	8 2005	11. M	Charles								

DHMH 16 Rev 6/95

			For State	State of I	Maryland		artmeni					0.0	0.57	
			Registrar 1. Decedent's Name (First, Middle,	Last)			incate	01 2			2. Date of Dea		U5	3-Time of Deeth
	Physici: Medic/		Willie William								Aire	8 2	Yeer	10:07AM
	Examin		4a. Facility Name (If not institution,				·		Location		0	4c. County	of Death	
			Union Memoria 5. Social Security Number		Age (In yrs. la:	st birthday)	If Under	1 Year	imore		8. Date of Birtl (Month, Day	h	9. Birth	plece (State or Foreign
	uneral irector		222-10-5688	1 ₹ M 2□F	91	Yrs.	Months	Days	Hours	Min.	July 12	2, 1914	Cou	unk unk
pur	*		Usual Residence of Decedent 10a, State 10b, County		10c. City	Town or Lo	cation						1.	10d. Inside City Limits
Maryla	f eho	ō	MD			altimo								1 Yes 2 No
the l	r 28a	irec	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?
death with the Maryland	23a o	aiD	2700 N. Charles	Street				2	21218				USA	
	Items Der D	Funeral Director	11. Marital Status	12. Was Decede	s?	. 13. 1	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		e - Ameri ck, White,	can Indian, etc.
G Z I Z I 3-0030 filed within 72 hours after Hudiana), or	byF	1 Never Married 2 Marrie 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2	2 ₹ No	Specify:	:		Specif	у: b1a	ack
2-C	netura lical E	eted	15. Decedent's (Specify only highest			16a. Dece	dent's Usua kind of wor	I Occupa	ation Juring mos	st of worki	na unk	16b. Kind of B	usiness/In	ndustry unk
Mithin a	hen B Me	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	e retired)					
illed A	other in	င်	unk 17. Father's Name (First, Middle, La	unk est)			1	ınk	18. Mothe	er's Name	(First, Middle,	Maiden Suman	ne)	unk
yland ould be fit	in result in the marked other than "netural", or liems 23a or 28a-f show other traumatic event, the Medical Examinational be notified at	To B												UIIK
S S	le me	ľ	19a. Informant's Name/Relationshi									r, City or Town,		
Tan L	em 27 ther t		Union Memorial I	lospital	20b. Pla	201 E			sity		Baltimo	ore, MD	212 City or T	
Pages	nt: If it		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☑ Other (Spe	Removal from Sta	110	metery, crer	natory`or o	ther plac	θ)] 				,	
permit. Pages	Important: If its eny injury or of once.		21. Signature of Puneral Service Li Ronald S	censee	goldor 1	St	Name an Late A	nato	omy B	oard 2120		Baltim	ore S	Street
Call:	1		23a. Part1. Enter the disease, or c shock, ir heart failure. List or	omplications that cau	sed the death.							rest,		Approximate Interval Between
Phy	sician		Immediate Cause (Final disease or condition	Rila	Hera	l F	nei	in	oni	2				Onset and Death
	ledical aminer		resulting in death)	Due to (or	as a conseque	ence of):								
46	٧.,	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseque	эпсө ођ.								
cuted	nd ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
fou, te be executed	cian a	al Ex	resulting in death) Last	Due to (or	as a conseque	ence of):							1	
0	physics s the b	<u>.0</u>		d										
× 5	attending physician and for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnan		DEctopic pr	000300 0					ite of deliv	•
. 8	ed by the atter	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		t at time of dea		Other (sp					М	onth	Day Year
That The State of	ad by 1 detact		Part II. Other significant condition	s contributing to deal	th but not result	ting in the u	nderlying c	ause givi	en in Part	l.	23e. Did to	obacco use con	tribute to t	the cause of death?
OrdS, P	5 8	d by				_					101	res 2□No	3 🔲 Pro	bably 4 Unknown
S S	SCA	Completed									24a. Was	an 24b.	Were auto	opsy findings available ompletion of cause of
r å	pag	Com									perfo 1 Tyes	rmed?	death? 1 🗌 Yes	21XN0
OT VITAL	ii. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			-0	Oth	0.0		(Check only o			
	ar this aral di	n: To	1 ☐ Yes 2 No 27. Manner of Seath	28a, Date of	Injury	R/Outpatier 28b. Time o		8c. injun Worl	4 (1) (4)			dence 6 Oth		ify)
VISION	deall ctor: Afte y the fun	atio	1 Natural 5 Pending 2 Accident investiga	ition	Day Year)	Injury	М		K? Yes 2□]No				
DIVISION for Attending	Director: A	Certification;	3 Suicide 6 Could no 4 Homicide determin	280. Place of	Injury - At hor , etc. (Specify)	ne, farm, sti	reet, factory	r, office			28f. Location (S City or Tox		ber or Run	al Route Number,
To the Hospital or	within 24 hours after de To the Funeral Direct completely filled in by the	edical C		Physician: To the b xeminer: On the bas and manne	is of examination	on and/or in	vestigation	in my o	pinion, dea	ath occurr	ed at the time,	date and place.		
To the	To the	Med	29b. Signature and title of certifier	and manne	1 318180.		290	c. License	e number			29d. Date signe	ed (Month,	Day, Year)
			Vin No	my	M.D	,	F	TZ	438	946	-F40	Ang.	8,	2005
			30. Name and address of person w	no completed cause	of death (Item	23а) (Туре,	Print)	Aa	. 0	11~	-F46	9		
	St	ate	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signatu	ure ure	1-12-1	OY	100	1105	the last			
	Regist		AUG 1 8	2005	Eller A	4 A	sec.							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygienes

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

death with the Maryland

Baltimore, Maryland 21215-0036

has certificate or Attending Physician: After t Diractor: the within 24 hours a To the Funeral L

Be

မ

Certification:

Medical 29b. Signature and PATEL

<u>Hypothyroid</u>

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 XNatural

2 Accident

3 T Suicide

4 🗌 Homicide

(Check only one)

29c. License number

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D58962

1 ☐ Yes 2 ☐ No

15/ 2005

who completed cause of death (Item 23a) (Type, Print) 2309 Shorefield Road

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

and manner stated.

M.D. SHASHANK 32. Registrar's Signature

5 Pending investigation

6 Could not be determined

Wheaton, Maryland, 20902

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 🔯 No

28d. Describe how injury occurred

31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND TTEM #5 PER FH G846 8 Gertificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 45AM AUGUST 2005 WIENER 16 MAURICE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HOSPITAL OF BALTIMOR PALTIMORE CIT N/A 8. Date of Birth (Month, Day, Year) 10/11/1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 212-30-5515 **Funeral** MD 86 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28e-f show other treumetic event, the Mcdical Examiner must be notified at 1 Yes 2 □ No BALTIMORE N/A Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23e 6300 RED CEDAR PLACE #211 21209 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 Married 1 Never Married 1 ☐ Yes 2 No Specify: SpecifWHITE ŏ Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced "netural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) PHARMACIST PHARMACEUTICAL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be find Mental H UNOBTAINABLE WIENER UNOBTAINABLE I SRAFI. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lapartment of Health at Importent: if item 27 Is r. any injury or other transponds. 6300 RED CEDAR PLACE #211 - BALTIMORE, MD 21209 GERALDINE WIENER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/17/2005 WOODLAWN, MD BETH TFILOH CONG. `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3DAYS. SEPTIC SHOCK Priysician /Medical LOSTRIDIUM Examiner DIFFILILE WLITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by Coronary 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? typertension 2 No 25. Was case referred to medical examiner? To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending s after dec 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IM.B. SINA 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 8 2005 Joans. Registrar

DHMH 17 Rev 1/2001

WIENER

ORIGINAL

	For 1_ State	State of Maryland / D	·			
	Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of De	2. Date of D	Reg. No. 1 5	2 7 0 5 9
Physicia	Leanard Lerau	Zebeck		Month	18+ 16 2005	8,20 AM
/Medica Examine	A. E. His Alexan / March institution since at	gton Medical Ce	4b. City, Town, or Lo	Dunie	4c. County of Death	rundel
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs. last birth		f Under 24 Hrs. 8. Date of B Hours Min. (Month, I June	Day, Year) Cour	lace (State or Foreign htry) SYLVANÍA
g	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location	June		Od. Inside City Limits
death with the Maryland ms 23e or 28e-f show			Pasadena			1 ☐ Yes 2 X No
h the l	Maryland Anne Arun 10e. Street and Number		10f. Zip Code		10g. Citizen of What Cour	ntry?
ath with	7734 Suitt Drive	o.w. o		122	U.S.A.	an Indian
1036 1036 1036 1019 after death with the Marylar let', or items 23a or 28e-f show Exertified at	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? I		nanic Origin? (Specify Yes or Mexican, Puerto Rican, etc.)		etc.
CONA! 5-0036 72 hours after "neturel; or ite	3 ☐ Widowed 4 🏋 Divorced	Year or Dates: WW II		Specify:	Specify: White	
715- 115- 11 72 III 72	(Specify only highest grade Elementary/Secondary (0-12) 6th Grade	ation completed) College (1-4or 5+)	Decedent's Usual Occupatio (Give kind of work done dur. life. DO NOT use retired)	on ring most of working	16b. Kind of Business/Ind	dustry
Ind 2121 be filed within tall Hygiene. Ind other then event, the M	6th Grade	College (1-401 34)	Millwright		Steel	
Po distriction of the control of the	17. Father's Name (First, Middle, Last) Peter Zeback		18	8. Mother's Name (First, Midd Violet Go	le, Maiden Sumame) LOTY	
and and sum sum	19a. Informant's Name/Relationship (Typ			d Number or Rural Route Num		Code)
e, N 1 and 1 and 1 ealth 9m 27 ther tr	Ronald Zebeck 20a, Method of Disposition	20b. Place of	Disposition (Name of	Trail, Mound,	MN 55364 20c. Location - City or To	own, State
altimore mit. Pages 1: partment of He portent: If iten y injury or oth	1 X Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	od Cemetery of other place)	8/20/2005	Baltimore, 1	Maryland
Baltimor. permit. Pages Department of Importent: If its any injury or o	21. Signature of Funeral Service License		22. Name and Address	of Facility Schimunel r Rd., Baltim	Funeral Homore, MD 21236	es
	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death. Do no e cause on each line.		1 0 1		Approximate Interval Between Onset and Death
Pnysician / /Medical	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of	nd favi	3 2	n Comcor	
Examiner	Sequentially list conditions,	Due to (or as a consequence of			1	
pei ist	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	nf):			
'60, (7) be executed sician and burial-transit	that initiated events resulting in death) Last	Due to (or as a consequence of	of):			
18760, crate be ex physician a the burial						
Box 6 eath certific	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delive	
P.O. B. that the death ed by the atte detached for	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions core	4 □ Pregnant at time of death 9 □ Unknown	5 Other (specify)		Month	Day Year
Division of Vital Records, P.O. Box 68760, (a) To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Part II. Other significant conditions cor	tributing to death but not resulting in	the underlying cause given		t tobacco use contribute to tl ∃Yes 2 □ No 3 □ Prob	,
Division of Vital Records, to attending Physicien: The law requires tatler death. Director: After this certificate has been signe in by the funeral director, page 2 should be a	Complete			24a. W	topsy prior to co	psy findings available mpletion of cause of
al Re i: The f				1 ☐ Yes	/	2 No
f Vital F ysicien: Th is certificate director, pag	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	ospital: 1₩Inpatient 2 ER/Out	Other	26. Place of Death (Check only 4 Nursing Home 5 Re		iv)
On of ding Phy h. After thii funeral c		28a. Date of Injury 28b. T	ime of 28c. Injury a Work?		e how injury occurred	,,
risio Attendii death. octor: A	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, far			(Street and Number or Rura	al Route Number,
Div	U	building, etc. (Specify)			own, State)	
Divis To the Hospitel or Atte within 24 hours after de To the Funerel Direct completely filled in by the	29a. Certifier 15 Certifying Phys (Check only one) 29h. Signature and title of celtifier	sician: To the best of my knowledge ter: On the basis of examination and and manner stated.	, death occurred at the time, d/or investigation, in my opin	, date and place, and due to the nion, death occurred at the tim	e cause(s) and manner as s e, date and place, and due to	tated. o the cause(s)
To the within To the compl	29b. Signature and title of celtifier	2 123	29c. License r	number	29d. Date signed (Month,	Day, Year)
· *	30. Name and address of person who co	moleted cause of death (Item 23a) (Type, Print)	. / .	08/16/7	V~3
10	KOFI BOA	ITEM, JU	1 140001	tal Dr. 6	m 1500 5	(m) /1
Sta Registra	200	37 Registrar's Signature	Sporte			

		-	For State Registrar	State of Ma	aryland	-	rtment of				ene ()5	27059
			Decedent's Name (First, Middle, L.)	ast)	-					Date of Death	j. 140 o		3. Time of Death
	nysicia	_	Edward A. Aa	ronson					l A	Month August	Day 1, 20	Year 005	8:45 A. M
	Medic xamin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town	n, or Location of	of Death		4c. County	of Death	
			5610 Wisconsin A	venue, Bldg	g 2 Ap	t 301		Chase			Monte		
	nerai ector		577-34-5543	Sex 7. Ag	96 (In yrs. Ia:	st birthday) Yrs.	If Under 1 Ye Months Day		Min. Au	Date of Birth (Month, Day,) gust 1((ear) 1908	9. Birth Cou Ma	place (State or Foreign Intry) aryland
and	2		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ation						10d. Inside City Limits
Maryl	a pai	50		m 0 1477	Chorr	y Cha	7.0						1√DYes 2 No
the	rrott	rect	Maryland Montgo	nery	Gliev	y Glia	10f. Zip Cod	e		10	g. Citizen of V	/hat Cou	intry?
h with	at the		5610 Wisconsin A	venue, Bld;	g 2 Ap	t 301		20815			U.	S. A	Α.
deet.	E DE	Funeral Directo	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.		Vas Decedent o Yes, specify C	of Hispanic Ori	igin? (Specif	y Yes or No-		e - Amer k, White	ican Indian,
after a		y Fu	1 Never Married 2 Married		No	1	☐Yes 2X			,	Specify		
Sin of	al Ex	d by	3 Widowed 4 Divorced	Year or Dates:		160 Danad	ant's Herel O-			1		Wn:	ite
IL Z IZ IS-UUSO filed within 72 hours after deeth with the Maryland Hygiene.	o die	Completed	15. Decedent's (Specify only highest of	rade completed)		(Give	ent's Usual Oci kind of work do. OO NOT use rel	cupation <i>ne during</i> mos tired)	st of working	11	5b. Kind of Bu	siness/ii	naustry
d withi	Ne O	omp	Elementary/Secondary (0-12)	College (1-4or!	5+)	Attor					Law		
ld be filed ental Hyg	vent,	a l	17. Father's Name (First, Middle, La	st)	,					irst, Middle, M.		e)	
Menta	atic e	To B	Reuben Aaronson					E	sther	Shapir	O		
DENLIMOTE, METYISTIC ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mertal Hygiene.	r traum		19a. Informant's Name/Relationship David E. Aaronso							hesda,			^{ip Code)} 20816
is 1 au	othe		20a. Method of Disposition		1		sition (Name of natory or other p		Date	2	c. Location -	City or T	own, State
Page nent c	30		1X□ Burial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spe	tytRemoval from State					8/3/2	2005 Fa	alls Ch	urc	h, Virginia
Daltimore, permit. Pages 1 a Department of Hea	any Inj		21. Signature of Funeral Service Lic	Stotte	imu	Ed 10	Name and Ad Ward Sa	dress of Facility	neral Pike.	Direct: Kockvi	ion, In	ic.	and 20852
TUP'V			23a. Part1. Enter the disease, or co shock, or heart failure. List on			Do not ente	er the mode of	dying, such as	cardiac or re	espiratory arres	it,		Approximate Interval Between
Phys	ician		Immediate Cause (Final disease or condition	_a Dysph:									Onset and Death
	dical		resulting in death)	Due to (or as		ence of):							
Exan	illiei	L	Sequentially list conditions,	b. Chron	ic Ohs	struct	ive Ful	monary	Disea	ase		_	
pe	sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as Demen		ence of):							
oU, be executed	and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as		ence of):							
ate be e	nysician and the burial-transit	ical E		d. Perip	heral	Vascu	lar Dis	sease					
certificate	attending prysider is a street	/Mec	IF FEMALE:	23c. If yes, outcome	of pregnant	cv					22d Dat	o of doli	1084
death cer	atten for u	iclan/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetel o	death 3	Ectopic pregnal Other (specify				23d. Dat Mor		Day Year
. te d	ny tne ached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown									
s that the	been signed by the should be detached	by PI	Part II. Other significant conditions	9		•	, ,	given in Part I	l.			ibute to	the cause of death?
COTOS, wrequires	an sig	leted t	Atheroscleroti	.c Cardiova	scular	r Dise	ase			1 🗀 Yes	2 No	3 Pro	bably 4 Unknown
	nas 3e 2	Complet								24a. Was an autopsy perform 1 Yes	l r	prior to co death?	copsy findings available ompletion of cause of
_ (ပို	25. Was case referred to medical					26 Place	o of Death //	1 ☐ Yes 🙇		∐Yes	X □ No
90 ,		0 8	examiner? 1 😾 Yes 2 🗆 No	Hospital:	ent 2 E	R/Outpatien	t 3 DOA	0.1		5X Residen		er (Spec	ifv)
_ `	<u>a</u> ⊒	n: T	27. Manner of Death	28a. Date of Inju	ury 2	28b. Time of	-	njury at Work?		d. Describe hov			-,,
Attending r death.	or: Arter	atlo	1 ♠Natural 5 ☐ Pending investigat	ion	, , , , ,	mjury		Yes 2□]No				
DIVISION I or Attending after death.	Ulrector I in by th	ertiflcation:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ad 28e. Place of In	jury - At hom tc. <i>(Specily)</i>		eet, factory, offi	ce	28f	Location (Stre City or Town,	et and Numb State)	er or Rui	ral Route Number,
To the Hospital or Attend within 24 hours after death	le Funera. Ietely fillet	edical C	29a. Certifier (Check only one) 1 X Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination	ledge, death on and/or inv	occurred at the restigation, in m	e time, date ar ny opinion, dea	nd place, and ath occurred	d due to the cau at the time, dat	use(s) and ma e and place, a	nner as and due	stated. to the cause(s)
To th within	comp	Me	29b. Signature and tyle of certifier	1			29c. Lio	ense number		29	d. Date signed	1 (Month	, Day, Year)
75			> / mil		د		D3.	5579		A	ugust	1, 2	.005
			30. Name and address of person with Susan J. Miller	o completed cause of c	death (Item :	23a)(Туре, ip Н i	Print) L1 Terra	ace, Be	ethesd	a, Mary	land 2	0816	
F	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 4 2	32 Regist									,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
				poor	-	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland /		tment of F ficate of		Mental Hy	giene Reg. NQ	005	27060
	S i		1. Decedent's Name (First, Middle, Las	t)					2. Date of De		600	-3. Time of Death
	Physicia /Medic		Barbara Ann	Allen					July	31	2005	0608 AM
	Examin		4a. Facility Name (If not institution, give				-	r Location of Dea		4c. 0	County of Death	
			5. Social Security Number 6. Se		loo Cod		If Under 1 Year	Himo If Under 24 Hi		rth	O Bist	Place (Chate or Francisco
	Funeral Director			_M 2 X F	70		Months Days	Hours Mi		ay, Year)	35 Mar	place (State or Foreign intry) yland
	yland yland		10a. State 10b. County		10c. City, Tox	wn or Loca	tion					10d. Inside City Limits
	a-fst	ctor	Maryland Baltimo	re	Gwynn	0ak					-	1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	intry?
	eth w	rai	5915 Prince Geor				2120				ited Sta	
21215-0036	72 hours after deeth with the Maryland natural', or itams 23a or 28a-f show Jicki Evarni or most be routified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			us Decedent of H Yes, specify Cuba Yes 2 No		Specify Yes or No arto Rican, etc.)		4. Race - Ameri Black, White, Specify: Wh	
2-0	72 ho	ted	15. Decedent's Ed (Specify only highest grad	ucation	168	a. Deceder	nt's Usual Occup	ation	odrina	16b. Kin	d of Business/In	
21	d within jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)			during most of w d)	orking			
2	20 E to 100		12 17. Father's Name (First, Middle, Last)			Home	maker	40 Mathada N	(Fine Mid-4)		Home	
Maryland	~ ~ 0 %	To Be	Archibald Davis	, Sr.					ame <i>(First, Middl</i> e e Stitle	, Maiden S	sumame)	
ary	should be and Menta e marked umatic so	-	19a. Informant's Name/Relationship (7	ype, Print)	19	b. Mailing	Address (Street	and Number or I	Rural Route Numb	er, City or	Town, State, Zij	o Code)
	and 2 ealth a n 27 ie		Robin Stancliff	/ Daughter				eorge S	t. Gwyni	n Oak	, MD 21:	207
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 ie merked any injuty or other traumatic sv once.		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify	Removal from State	1		ion (Name of tory or other plac aven Cer	· nug	Date 5, 05		eation - City or To Ter Spri	
Balt	permit. Departr Importe any inje		21. Signature of Funeral Service Licen:	See Wh				ss of Facility D Park Dr	eVol Fun . Gaith	eral	Home urg, MD	
	Mar.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death. Do	not enter	the mode of dyin	ng, such as cardi				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· Mot	ナナモナ	B	(405+	Can	W/		Į.	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence							year)
		-	Sequentially list conditions,	b. Due to for an	a consequence	(vertice)						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		400,000	,.						
o,	rificate be executed to physicien and as the burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as	a consequence	of):						
68760,	ate be nysiciv	Aedicai		d								
¥ 68		Med	IF FEMALE:							- 1		
.O. Box	The law requires that the death cert tte has been signed by the attendin bage 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetel deat		ctopic pregnancy Other (specify)	<u>'</u>		23	3d. Date of delive Month	ery Day Year
S, P	s that ned b e deta	by Pł	Part II. Other significant conditions co	ontributing to death be	ut not resulting	in the und	ertying cause giv	en in Part I.	23e. Did 1	obacco us	e contribute to t	he cause of death?
rds	aquires en sign								1 🗆	Yes 2□]No 3□Proh	bably 4 Onknown
I Record		Completed							24a. Was auto perfo		24b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available impletion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hagnital	N (Lau		eath (Check only	one)		
of	Phys rthis ral dii	To.	1 Yes 2 No	Hospital: 1 ☐ Inpatie	-	utpatient Time of	3 DOA Oth	4 Rursing	Home 5 ☐ Resi 28d. Describe			fy)
	th. Th. After tuner	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	Wor	k? Yes 2 □ No	26d. Describe	now injury	occurred	
Division	st or Attending after death. I Director: After d in by the fune	Certification	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, f c. (Specify)	farm, stree			28f. Location (City or To		Number or Rura	al Route Number,
	Hospite 14 hours Funere tely fille	edical C	29a. Certifier (Check only one) 2 Medical Examone)	ysician: To the best of tiner: On the basis of and manner sta	examination a	ge, death o	ccurred at the tin stigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) a date and p	and manner as s place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	3		AT AT	Fredora.	Physic	4 6-	35	1853		5-1-	31. 7	2005
			30. Name and address of person who	MM	eath (Item 23a)	(Type, Pr	int)	venue	Bai	han	~ 2	1229
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 4 20	05 Registra	ar's Signature	Span	di.					

ALIEN, BARBARA

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 July **Physician** 29, Charles Allyn Avant 11:30 p /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Kensington Nursing Center Kensington Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 12-18-1931 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1₩ 2□ F Hours Min. 578-46-4060 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County e filed within 72 hours after death with the Marylar al hygience or other than "natural", or fteme 23a or 28a-1 show onthe than "natural", or fteme must be notified at 1 ☐ Yes 2 No Directo Maryland | Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3000 McCômas Avenue 20895 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 None None permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked othe any Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eleanor Effler Charles A. Avant 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9901 Blundon Drive, Apt. 101; Silver Spring, MD20902 Robert Avant-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXX remation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)
21. Signature of Fure al Service Light se Fort Lincoln Crematory 08-03-2005 Brentwood, MD 22. Name and Address of Facility Simple Tribute any In 1040 Rockville Pike, Rockville, Maryland 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 6000 perenonia disease or condition resulting in death) /Medical Due (or as a consequence of): Examiner HE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the as attending I IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) bed 1 1 ☐ Yes 2 ☐ No Records, P.O. the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 / No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan autopsy performer Yes 2/2 1 Yes Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: A ursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 🗌 Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28c. Injury at Work? 27. Manner of eath 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. I Director: After t Certification Injury Natural Accident 5 Pending 1 Tyes investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006,1 ten Doos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3308 Rocac 31. Date filed (Month, Day, Year) gistrar's Signature State AUG 0 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August **Physician** NANCY RIEMAN AUSTIN 1932 2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hospita 6. Sex Talbot Memoria 8. Date of Birth (Month, Day, Year)

JAN. 3, 1914 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Days Hours Min. Yrs. 220-66-4481 91 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. Count 10c. City, Town or Location ?7 is marked other than "natural", or items 23e or 28e-f ehow traumatic svent, the Medical Evant are must be notified at 1 Yes 2 No Director TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8914 MARENGO ROAD 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coilege (1-4or 5+) Elementary/Secondary (0-12) 12 -0-HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental HENRY RIEMAN, JR. NANCY R. HANNIFAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i JOHN H. AUSTIN/ SON P.O. BOX 1095, ST. MICHAELS, MD 21663 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTER, LLC permit. Pages 1 Department of H Importent: if ite 8-8-2005 STEVENSVILLE, MD ³ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee any ir FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. C.F.S.P. m. Ostrowski Josaph 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 24 hove FENTE Hommer hasic CANTOVAILU) Ar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2- No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 1 ☐ Yes 2 ☑ No 1 Inpatient 3 DOA 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Diractor: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4 nom 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUDWIG J. EGLSEDER, M.D., 503 CYNWOOD DRIVE, EASTON, MD 21601 3 Registrar's Signature 31. Date filed (Month Gy 0'8 2005 State Registrar

DHMH 17 Rev 1/2001

Nancy Austin

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Tinge of Death Day **Physician** Edward Breighner 2005 Leo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegan imberland HOSPital emorial If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 M 2 □ F Yrs. 215-36-9133 Director Mar 20, 1941 MD Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show traumatic event, the Medical Examiner must be notified at MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Director permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hyglene. Importent: If item 27 Is marked other then "natural pages." 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 241 Williams Street 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) co-owner/operator Breighner's Cabinetry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leo P. Breighner Clara Loretta Wolfe Breighner 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 241 Williams Street W. Jean Breighner wife Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Mary's Cemetery 8/17/2005 Cumberland MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Huneral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Earl. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final . Hemorrhage mic Frontal Physician disease or condition resulting in death) /Medical Due to (or as a consequence d) Examiner Sequentially list conditions, if any, leading to himse diate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) · the 1 ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? page 2 certificate 1 Yes 2 No or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) Hospital: 1 Tes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the f within 24 hours after deatl To the Funerel Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Namber, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Hospitel 29a. Certifier Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Fo the h 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. A Figueroa
31. Date filed (Month, Day, Year) Heig Medical Johnson 32. Ingistrar's Signature State Registrar AUG 1 8 2005

ORIGINAL

DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of M	arylan				ealth a		R	eg. No.	005	2701	64
	Physici	an	Decedent's Name (First, Middle, Last,								2. Date of Dear Month		2005	3. Time of I	
	/Medic	al	John Alfred 4a. Facility Name (If not institution, give	Barrick			4b City	Town or	Location of	of Dooth	August	7	2005 county of Deat	2:45	_a ^M
	Examin	er	Dennett Rd. Mano			2	_	akla		Di Deatri			rrett	1	
	Funeral		5. Social Security Number 6. Sec	7. Ag		last birthday)	If Under Months	1 Year	If Under	24 Hrs. Min.	8. Date of Birth	Vaarl	9. Birti	nplace (State or untry)	r Foreign
	Director		215 36 8894	M 2□F (57	Yrs.	Months	Days	Hours	Min.	8. Date of Birth Month, Day March	1,]	9 18	MD	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City	v Limits
	Maryl f sho	ŏ	MD Garrett		Deer	Park								1 🗌 Yes	•
	r 28a	Lec	10e. Street and Number				101. Zip 215	Code			1	0g. Citize	on of What Co	untry?	
	th wit	aD	215 Chadderton So	chool ka.			215	50				USA			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinational Remodified at ODGE.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	,	'	Was Deced f Yes, spec 1 ☐ Yes	city Cuba	n, Mexicar	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)	1	Race - Ame Black, White		
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad			16a. Deced	kind of wor	rk done d	turina mos	t of workir	na	16b. Kind	d of Business/l	ndustry	
2	han "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	DO NOT us	se retired)		.9				
2	filed w Hygier other th	S	12 17. Father's Name (First, Middle, Last)			Cle	erk	Т	18 Mothe	r's Name	(First, Middle, I		di-Care	2	-
and	d be f antal h red of	o Be	Dwight Barrick								Burdock	VIAIGOIT O	umame/		
Z	should and Men s marke umatic	ဥ	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	g Address	(Street a			l Route Number	City or	Town, State, Z	ip Code)	
	and 2 alth a 127 Is		David A. Burdoc	k		710	Chur	ch S	t. K	itzm	iller,	MD	21538		
ore,	es 1 a of He fitem r othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	lomoval from State		lace of Dispo emetery, cren	sition (Nan	ne of ther place	e) !	D	ate	20c. Loca	ation - City or	Town, State	
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Baltimore,	permit. Depart import any inj		21. Signature of Funeral Service Licens	Sundon	k	71			s of Facilit	Dav	id A. B miller,	urdo MD	ck FH 21538		
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that cause ne cause on each li	d the death ine.	. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Betw Onset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	pancre	eatic	cance	r							month	
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):									
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequ	uence of):									
	uted d ansit	Examiner	Cause (Disease or injury that initiated events												
o,	ate be executed hysician and the burial-transit	Еха	resulting in death) Last	Due to (or as	a consequ	uence of):									
3760,	ate be hysici he bu	Ical		d											
9 ×		by Physiclan/Med	IF FEMALE:	3c. If ves, outcome											
Вох 6	es that the death certific igned by the attending p be detached for use as	clan	in the past 12 months?	1 ☐ Live birth	2 Fetal	death 3	Ectopic pro					23	d. Date of delimental delimen	-	ear
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<u>a</u>	s that ned b e deta	y Pł	Part II. Other significant conditions con	ntributing to death b	out not resu	ulting in the ur	nderlying ca	ause give	en in Part I.		23e. Did tot	acco use	contribute Io	the cause of de	ath?
rds	quire an sig						_				1 □ Y€	s 2 🔀	No 3□Pro	bably 4 Ur	nknown
Records,	aw re	Completed									24a. Was a		24b. Were aut	opsy findings a ompletion of car	vailable
	The ate ha	Com									perform	ned?	death? 1 ☐ Yes	2 □ No	450 01
/ita	cian: ertific ector.	Be (25. Was case referred to medical examiner?	la a sitale				10.	-	of Death	(Check only on	9)	7 1		
Division of Vital	Physi this o	-T	1 ☐ Yes 2 💢 No	fospital:		ER/Outpatien 28b. Time of		A Othe 8c. Injury	TANTING	-	ne 5 Reside			ity)	
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/IS	Attending ir death. ector: After by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	jury - At ho	me, farm, str	eet, factory				8f. Location (St	reet and	Number or Ru	ral Route Numb	er,
á	al or safte	Serti	4 ☐ Homicide determined	building, et	tc. (Specify	")				1	City or Town	, State)			
	To the Hospital or Attending Physician: The law requir within Z4 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	Medical (29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Exami	sician: To the best ner: On the basis o and manner st	f examinat	wledge, death tion and/or inv	occurred a	at the tim in my op	e, date an pinion, dea	d place, a th occurre	nd due to the ca	iuse(s) a ate and p	nd manner as lace, and due	stated. to the cause(s)	
	To the within To the Comp	Ž	29b. Signature and title of certifier		9		29c		number	1	-0 29	d. Date	signed (Month	Day, Year)	
			1 Dans	When	PC	5		97	26	15	4	tu	35	2005	5
			30. Name and address of person who co					0-1	.1 1	λ/ -	1 c 1	2155	0		
	Sta	to	P. Daniel Miller, 31. Date filed (Month, Day, Year)	DO 69 W		cres D	rrve,	, var	Land	, mai	утапа	2155	U		
	Registr		3 4 4 4	8 2005	France	- B	Show	(h)							

		•	For Stata Registrar	State of N	Maryland / Depa	artment of H			giene Reg. No. 2005	27065
			1. Decedent's Name (First, Middle, Las	1)				2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Clarence Ste	even	B1ake		_	July	29, 2005	20:24 M
	Examin	_	4a. Facility Name (If not institution, give	street and number	er)	4b. City, Town, or	Location of Death		4c. County of Death	
			Malcolm Grow H	Hospita	1		Springs		Prince G	
	Funeral		Social Security Number 6. Security Number		Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Nov • 30	h y, Year) 9. Birth	place (State or Foreign intry)
	Director		5/9-/2-1431	X M 2□ F	51 Yrs.			Nov.30	0, 1953 Wa	sh.,DC
	D >	-	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Le	ocation			T T	10d. Inside City Limits
	aryla sho	5								1;⊠Yes 2 □ No
	Me M	ectc	Md. P.G.		Suit	10f. Zip Code			10g. Citizen of What Cou	intry?
	with the	급	10e. Street and Number		#202		1.6		_	
	s 23	rai	3605 Silver Pa	TK Driv		Was Decedent of Hi		pecify Yes or No	United St	
	er de Item	Ë	11. Marital Status 1 □ Never Married 2 Married	Armed Force		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, White	
36	I', or	by F	3 Widowed 4 Divorced	If Yes, Give Year or Date	2.7	1 ☐ Yes 2X No	Specify:		Specify: B1	ack
21215-0036	within 72 hours after death with the Maryland ene. Than "netural", or Items 23a or 28a-f show the Medical Examener must be notitied at	Completed by Funeral Director	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Business/li	ndustry
7.5	n n	pie	(Specify only highest gra	College (1-40	or 5+)	kind of work done of DO NOT use retired	nunng most of work ()	ung		
21,	filed withi Hygiene. bther than	E O	11			oute man			Wash. Tim	es
B	al Hy l oth	Be (17. Father's Name (First, Middle, Last)						Maiden Sumame)	
<u> a</u>	ould be Mental larked c	2	John W. Blake					H. Tho		
Maryland	and and ls m		19a. Informant's Name/Relationship (1		19b. Mail	ng Address (Street a	and Number or Rui	ral Route Numbe	er, City or Town, State, Zi	ip Code)
	and and and n 27		Pamela King/wit	e	Sui	Silver				- Ctara
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from Sta	ate /	matory or other plac	Θ)	Date	20c. Location - City or T	
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3alt	permit. Pa Departmer Importent any injury once.		21. Signature of Funeral Service Licen	565	1 1	2. Name and Addres		ruses Discusses	& Edwards	
ш	205 g g		23a. Party. Enter the disease, or com	auri		Bredstild (miles			Suitland	, Md • 20 /40 Approximate
4	Physician /Medical Examiner pruisi, transit pr	i Examiner	shock, or heart failure. List only immeriate Cause (Final disase or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c	as a consequence of): as a consequence of):	Alvers	la de	Card	covocular	Interval Between Onset and Death
.O. Box 6876	death certificate e attending phys id for use as the	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		h 2 ☐ Fetal death 3 at at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of delik Month	very Day Year
<u>α</u>	w requires that the been signed by th should be detache	d by Pr	Part II. Other significant conditions of	ontributing to deat	th but not resulting in the	underlying cause give	en in Part I.		obacco use contribute to Yes 2□No 3ဩ*Pro	the cause of death?
Vital Records,	e law has b	Completed						24a. Was autor perfo 1 \(\text{Yes} \)	osy prior to c ormed? death?	opsy findings available ompletion of cause of
ta	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	one)	
	ys dir	10	1 ☐ Yes 2 ⚠ No		patient 2 ER/Outpatie		4 Nulsing in		dence 6 □Other (Spec	ify)
0	ding Ph I. After th funeral	:uo	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month,	Injury 28b. Time (Day Year) Injury	Wor		28d. Describe	how injury occurred	
9		atic	2 Accident investigation				Yes 2 □No			
Division of	l or Atten after deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286, Place of	f Injury - At home, farm, s , etc. <i>(Specify)</i>	reet, factory, office		28t. Location (Street and Number or Ru wn, State)	rai Houte Number,
	dospital 4 hours Funerel ely filled	Medical Ce	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Example	ysician: To the be niner: On the bas and manne	est of my knowledge, dea is of examination and/or i r stated.	th occurred at the tin	ne, date and place, pinion, death occur	, and due to the rred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2. To the complet	Me	29b. Signapare and title of certifier			29c. Licens	e number		29d. Pate signed (Month	Day, Year)
			1 tall	KINI	11	MUZ	13260		08/02/0	5
	(1)		30 same and address of person who	completed cause	of death (Item 23a) (Type	Print)	NN/NG/L	11	The Marie	150-
	De		13600	160.	DAUBUS)	1647 CE	NA/NG/L	ad NE	#105 WB.	ha aus
	Sta	ate	31. Bate filed (Month, Day, Year)	32. Reg	gistrar's Signature		11-			
	Regist		AUG 0 4 2005	leen &	4 Sperks					

DOUGLES COMMUNITY HOSPITAL 5. Speals Security Number (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL 5. Speals Security Number (If not institution, give street and number) 2. Speals Security Number (Index 1 Year If Undex 24 Mrs. 8. Date of Birth Mark 1 100. State 100. County 100. State 100. State 100. County 100. State	9. Birthplace (State or Foreign MARTLAND 10d. Inside City Limits 1 Yes 2 No What Country? STATES ce - American Indian, tok, White, etc.
DOCTORS COMMUNITY HOSPITAL LANHAM	9. Birthplace (State or Foreign MARTIAND 10d. Inside City Limits 1 Yes 2 No What Country? STATES ce - American Indian, tok, White, etc.
219-36-9772 219-36-9772 219-36-9772 219-36-9772 219-36-9772 219-36-9772 219-36-9772 219-36-9772 219-36-9772 219-36-9772 219-36-9772 219-36-9772 219-36-9772 219-36-9772 219-36-9772 210-36-9772 211-36-9772 210-3	MARTIAND 10d. Inside City Limits 1 □ Yes 2 □ No What Country? STATES ce - American Indian, lock, White, etc.
Top State Top To	Tares What Country? STATES ce - American Indian, lock, White, etc.
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Superior	ce - American Indian, lock, White, etc. fy: BLACK
Superior	lusiness/Industry
HARUL EARL DROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town BETTY J. BUTLER / WIFE 4304 FAIRWAY VIEW TERRACE, UPPER MAR! 10b. Mailing Address (Street and Number or Rural Route Number, City or Town 10c. Method of Disposition of Library and State of Disposition (Name of Camelon), crematory or other place) 10c. Method of Disposition of Library and State of Camelon, crematory or other place) 10c. Marbury Theren. 10c. Description of Programs of Pacifity 10c. Marbury Fine Address of Facility 10c. Note of the state of Disposition (Name of Camelon), crematory or other place) 10c. Note of the pact of Camelon (Name of Camelon), crematory or other place) 10c. Note of the pact of Camelon (Name of Camelon), crematory or other place) 10c. Note of the pact of Camelon (Name of Camelon), crematory or other place) 10c. Note of the pact of Camelon (Name of Camelon), crematory or other place) 10c. Note of the pact of Camelon (Name of Camelon), crematory or other place) 10c. National Route Number, City or Town 10c. Marbury Investor Adversed (Name of Camelon), crematory or other place) 10c. National Route Number, City or Town 10c. Marbury Investor Adversed (Name of Camelon), crematory or other place) 10c. National Route Number, City or Town 10c. Marbury Investor Adversed (Name of Camelon), crematory or other place) 10c. National Route Number, City or Town 10c. Marbury Investor Adversed (Name of Camelon), crematory or other place) 10c. National Route Number, City or Tow	OVERNMENT
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Physician /Medical Examiner Page 1 18 18 18 18 18 18 18	
Physician /Medical Examiner Page 1 18 18 18 18 18 18 18	- City or Town, State MARYLAND
Physician /Medical Examiner Physician /Medic	ND 20640
C. Due to (or as a consequence of): Open continued events Continued and events Conti	Approximate Interval Between Onset and Death
Section Control of Pregnancy Control of	
	ate of delivery onth Day Year
s s s s s s s s s s s s s s s s s s s	tribute to the cause of death?
autopsy per all the page of t	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
1 Yes 2 12 No 1 Yes 2 No 1 Yes 2 No Yes	har (Spanis)
25. Was case referred to medical examiner? 1	
	ber or Rural Route Number,
by the state of th	
29b. Signature and title of certifier 29c. License number 29d. Date signer	
	ed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOISHIT AROUA 2118 GOOD COCIC RD CANGAM State State 31. Date filed (Month, Pay Year) AUG 0 4 2005 32. Registrar's Signature	12005

CHARLES

State of Maryland / Department of Health and Mental H	lygiene	
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For Stata Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** AUGUST 9, MARK EDWARD BANKY 2005 9:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2971 HICKORY VALLEY DRIVE WALDORF CHARLES If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Yrs. 48 Director 290-62-7056 MAR.4,1957 OHIO Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show iral, or items 23a or 28e-f shor | Examiner must be notified at 1 Yes 2000 MARYLAND Directo CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2971 HICKORY VALLEY DRIVE 20601 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 NMarried 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced WHITE "natural" eted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Compl U.S. GOVERNMENT than Elementary/Secondary (0-12) College (1-4or 5+) 12 DEPUTY DEPARTMENT HEAD DEPT. OF DEFENSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ages 1 and 2 should be fill int of Health and Mental H; Be STEVE J. BANKY RUBY E. HENRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAURIE J. BANKY -SPOUSE 2971 HICKORY VALLEY DRIVE WALDORF MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō ST. PETERS CEMETERY 8-12-05 WALDORF, MARYLAND 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646

Do not enter the mode of dying, such as cardiac of respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician COLOI /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician ician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) by Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 70 Other: 4 Nursing Home ome 5 esidence 6 Other (Specify)
28d. Describe how injury occurred 1 ☐ Yes -2-€ 28a. Date of Injury (Month, Day Year) in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: **Director**: After 1 | Natural 2 | Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Fjural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17 20646 0 70

DHMH 17 Rev 1/2001

State

Registra

31. Date filed (Month, Day, Year)

AUG 1 8 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** 1:55A BARTLETT AUGUST 2005 HENRY WILLIAM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NEWBURG 13393 BEACH HAVEN CIRCLE CHARLES If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months <u>X</u>M 2□ F 82 FEB.12,1923 VIRGINTA Director 230-14-313] Usual Residence of Decedent with the Maryland 10d, inside City Limits 10c. City. Town or Location 10a. State 10b. County ir than "natural", or itema 23a or 28a-f ehow the Medical Examitive must be notified at 1 ☐ Yes 2 X No Directo MARYLAND CHARLES NEWBURG 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 13393 BEACH HAVEN 20664 CIRCLE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√DYes 2 □ No IfYes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŒNo Specify: Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) U.S. GOVERNMENT e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N.S.W.C. 12 DRDINANCE EQUIPMENT MECHANIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H is marked of WILLIAM HENRY BARTLETT 2 SARA STAPLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any njury or other traum QNCs. DEACH HAVEN CIRCLE, NEWFULC, 11 20664

Name of Date 20c. Location - City or Town, State LEATRICE Y. BARTLETT-WIFE 13393 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CHRIST CH. CEMETERY 8-11-05 WAYSIDE MARYLAND 22. Name and Address of Facility 21. Signature of Furneral Service Licenses M00479 RAYMOND FUNERAL SERVICE, P.A. Do not enter the mode of dying, such as cardiac of respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cayse on each tine. Immediate Cause (Finat disease or condition resulting in death) a è **Physician** 2 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □Yes 2 □ No Year Month Day 5 Other (specify) 4 Pregnant at time of death the 9□ Unknown detached 9 Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has 1 ☐ Yes 1 Yes 2 No Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 3 Sesidence 6 Other (Specify) 1 Yes 25 No 2 ER/Outpatient 3 DOA 2 After this funeral di 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of De th 28b. Time of Certification: 1-ENatural 2 Accident 5 Pending investigation М 1 □ Yes 2 □ No death. hours after deal 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated:

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To tha Function (Check only one) the License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MARKEN AUG 1 8 2005

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Registrar

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Funeral

Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State iral, or items 23a or 28a-f show Examinar must be rigitled at Alexandria Fairfax Director Virginia 10f. Zip Code 10e. Street and Number 22301 2303 Leslie Ave. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status I ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) other traumatic sysnt, the Medical 1 and 2 should be filed within. Health and Mental Hygiene. em 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Secretary 17. Father's Name (First, Middle, Last) Be LaVern Rasmussen 2 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2...
Department of Health at Important: If item 27 Is any injury or other trau once. Erwin N. Burlimann (Husband) 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01414 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Box 68760 iclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. should be 1 TYes Completed 24a. Was an autopsy 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Tyes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death
Natural
2 Accident 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined 4 | Homicide 29a Certifier Medical 29c. License number of certifier 29b. Signature and titl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21713 Dr. Zafar Malik 20311 Lappans Road Boonsboro, MD

For State of Manyland / Department of Health and Mental Hygiene State of Department of Health and Mental Hygiene Registrar Registrar Reg. No. Burlimann 2. Date of Death Month 1 Decedent's Name (First, Middle, Last) Susan Marie Year **Physician** August 12, 2005 10:49 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Reeders Memorial Home Boonsboro If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 5, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Months Days Hours 1 M 2 XF 1960 Yrs Pennsylvania 220/78/7149 10d. Inside City Limits 1X Yes 2 □ No 10g. Citizen of What Country? U.S.A. 14 Race - American Indian. Black, White, etc. Specify: White 16b. Kind of Business/Industry Medical 18. Mother's Name (First, Middle, Maiden Sumame) Donna Lou Stearns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2303 Leslie Ave. Alexandria, Virginia 22301 Date 2005 20c. Location - City or Town, State Smithsburg Crematory August 14 Smithsburg, Maryland J.L. Davis Funeral Nome 12525 Bradbury Ave. Smithsburg, Maryland 21783 Approximate Interval Between Onset and Death Years 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 301-432-8470 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M		epartmer Certifica			Mental Hy	/giene Reg. No2	05	270	7.1
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last</i> Davi	d Wilmer	Bristow				2. Date of D Month Augus		2005	3. Time of D 0120	A ^M
	Examir		4a. Facility Name (If not institution, give Union Hospital	street and number)			, Town, or Lo Lkton	ocation of Death	1	4c. Count			
	Funeral Director		5. Social Security Number 6. Se 212-62-9421 Usual Residence of Decedent	M 0000	e (In yrs. last birth	Months		f Under 24 Hrs. Hours Min.	8. Date of B (Month, D SEPT 8	ay, Year) 1954	9. Birthpl Count Mary	ace (State or I ry) Land	Foreign
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "netural", or Items 23a or 28e-1 show or other traumatic avent, the Medical Evanti or marke notified.	by Funeral Director	10a. State 10b. County Maryland Cecil 10e. Street and Number 146 Dutch Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	10c. City, Town Conow Ever in U.S.	ingo	7.7	anic Origin? (S Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	10g. Citizen of Unite(o- 14. Rac Bla	What Count Stat Ce - America ck, White, e	ces an Indian, etc.	
Maryland 21215-0036	filed within 72 hour Hygiene Sther than "netural ant, the Medical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ıcation	5+)	Decedent's Usu Give kind of wo life. DO NOT L Assemb]	ork done duri ise retired) er	ing most of wor		Manu	nobile Eactur	ustry	
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Baltimore, Ma	permit. Pages 1 and 2 s Department of Health an Important: If item 27 is: any injury or other trau <u>onca</u> .		Sandra Bristow/ W 20a. Method of Disposition 1 X Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,	ife	20b. Place of E cametery, G11p	6 Dutch Disposition (Na , crematory or in Manc	n Drive me of other place) or ork	e, Cono Augu 20	wingo, Date st 12,	Maryland	1 2191 - City or Tov	8 vn, State	
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8760,	Physician and /Medical Examiner physician and physician and physician and physician site private it is a physician and physician	dicai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Sw. Due to (or as c. Due to (or as Due to (or a) Due to	a consequence of the consequence	Ca 1 Ca ():	f Lu to 1	ng diver				Approximate Interval Betwe Onset and De	ath
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			Registrar 1. Decedent's Name (First, Middle, La	ast)		ortineat	e or beaut	2. Date of I		3. Time of Death
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	/Medic Examin		4a/Facility Name (If not institution, give		,	4b. City,	Town, or Location of		4c. Coup	ty of Death
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lan', C	uld be Mental irked c	To B	CHARLES LEE	COWART,	SR.		BETT	Ϋ́	CO	NWAY
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of	Phys	To To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	ient 2 ☐ ER/Outpa ury 28b. Tim	ne of	28c. Injury at	sing Home 5 Re 28d. Describ	e how injury occi	
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		For State	State	of Maryla	•	artment of H		d Mental Hy	giene		
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/Medio	cal	4a. Facility Name (If not institution			vert	4b. City, Town, o	r Location of D	eath fugic	4c. Coun	2005 ty of Death	12,00
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Funeral Director		5. Social Security Number 220-14-0410	6. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	Hours N	Hrs. 8. Date of Bin Month, Da DEC 1,	y, Year) 1921	9. Birthpla Country North	ce (State or Foreign
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Baltimo permit. Page Department o Importent: If any injury or		 4 □ Donation 5 □ Other (S 21. Signal re of Funeral Service 		Me	ethodis	t Cemeter 2. Name and Addre	ss of Facility_	2005	Cherry	Hill.	Maryland
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Box 6 eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr birth 2 ☐ Fet		Ectopic pregnancy				ate of delivery	
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IS, P.O. I	by Ph	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use cor	ntribute to the	cause of death?
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DIVISION I or Attending after death. Director: After din by the fune	Certification:	4 Homicide determ	ined 200. Plac	e of Injury - At high	home, farm, str ify)	eet, factory, office		28f. Location (S City or Tox	Street and Num yn, State)	iber or Rural F	Route Number,
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical C	(Check only 2 Medical	Examiner: On the	basis of examin	owledge, death	n occurred at the tin	ne, date and pl	ace, and due to the occurred at the time,	cause(s) and m	anner as state	ed.
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6		30. Name and address of person	who completed cau	use of death (Ite	ту23а) (Туре,	Print)		t prope 4	/	- //	h +
Sta	to.	If I- or Kas) 31. Date filed (Month, Day, Year)	32.	Registrar's Sign	A/JV nature	14 ern	rueso	of cupie 4	ospices	EIK	(0n,10)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amen ditem#25, perME, C847, 9/28/05 TT

State of Maryland / Department of Health and Mental Hygiene 10g, 24a per Dr/FH, C846, 08/18/05dhb

Certificate of Death

Reg. No. 27076 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Nancy Lee Carden Year 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNDERLANC der 1 Year If Under 24 Hrs. AlleGAN Acred MEARY HOSPITAL 7. Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 1 ☐ M 2 🔀 F 212-42-3442 Yrs. Director 62 Jan 26 1943 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits show irel', or items 23a or 28e-f shov Examiner must be notified at MDGarrett Swanton 1 ☐ Yes 2 ☑ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 104 Misty Mtn. Road 21561 Nativo American 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Native 1 ☐ Yes 2 ☐ No Specify: Specify 3 ₩ Widowed 4 Divorced American traumatic evant, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ages 1 and 2'should be filed within 1 of Health and Mental Hygiene. If item 27 is marked other then "r other traume": Elementary/Secondary (0-12) 12 College (1-4or 5+) Records Medical Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ Unknown Zeigler Winona Briggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John D. Carden, Jr. 104 Misty Mtn. Road, Swanton, MD 21561 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 XBurial 2 Cremation 3 Removal from State = 5 Crownsville Vet Cem Aug 12 05 Crownsville, MD Department of Important: If any injury or once. _4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hafer Funeral Service P 1302 National Hwy., LaVale, MD 21502 21. Stature of Funeral Service Licensee 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METABOLIC Physician ACIDOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter under, mg Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICA Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physiclan/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, QUADRIPLEGIA 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' No No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes -21546 Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To tha Funaral Diractor: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To tha 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D0062177 AUGUST 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE, CUMBERLAND MD 21502 SET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Streets ! Registrar

ORIGINAL

			1 - State of Ma		artment of F		nd Mental Hy	giene Reg. 2.00	5 2	27075
	Physicia /Medic		Decedent's Name (First, Middle, Last) ARTHUR THOMAS DAVIS				2. Date of Dea	3 ^{Day} 20	05	3. Time of Death 11:16 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) 213 GENTRY COURT		4b. City, Town, o	ROAD			RLES	
	Funeral Director		193-20-3205 X M 2□F 7	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours	Min. 8. Date of Birt (Month, Da SFPITMBE	R 8,1927	9. Birthp VIRG	lace (State or Foreign INTA
	uyland show	_		10c. City, Town or Lo					1	0d. Inside City Limits 1 ▼Yes 2 □ No
	ith the Marylar or 28a-f show	Funeral Director	MARYLAND CHARLES 10e. Street and Number	BRYANS R	10f. Zip Code			10g. Citizen of V		try?
	eath with	eral D	213 GENTRY COURT 11. Marital Status 12. Was Decedent E	ver in U.S. 13. \		0616 Hispanic Origi	in? (Specify Yes or No	UNITED 14. Race	STATI e - Americ	3011
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than *natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiting routile indiffications.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No. 1 ☐ Yes Give Year or Dates:	1946	If Yes, specify Cuba 1 ☐ Yes 🏋 No	Specify:	Puerto Rican, etc.)	Specify	BLAC	
21215-0036	iin 72 ho n *natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most	of working	16b. Kind of Bu	usiness/Ind	dustry
212	iiled with Hygiene ther thai nt, the		THE GRADE 11TH GRADE 17. Father's Name (First, Middle, Last)	DRI	VER	18. Mother	's Name (First, Middle,	FEDERAL		ERNMENT
Maryland	ould be Mental Merked o	To Be	JIM DAVIS			BESS	IE DAVIS			
Mar	und 2 shu alth and 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) SHIRLEY HAWKINS / DAUGHTER		-		or Rural Route Numbe			20640
nore,	ages 1 and of He		20a. Method of Disposition **Disposition 3 Removal from State **Description 5 Other (Secretary)		matory or other plac		Date UGUST 9,2005	20c. Location -		
Baltimore,	permit. P Departme Importan any injury once.		21. Softur of Fundal Soft Losse Landia C. THORNION JOHNSON MOOF				ME, P.A. D, INDIAN HEA			
			23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line Immediate Cause (Final	he death. Do not ent						Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) Due to (or as a	onsequence of):	Jenu	K				
	*	Sequentially list conditions b.								
Ć.	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	consequence of):	geractis					
38760,	icate be physicia s the bur	icai	d							
Box 6	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No IF FEMALE: 23c. If yes, outcome of 1 □ Live birth 2	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	/		23d. Dat Moi	e of delive	ry Day Year
P.0.	t the		9☐Unknown 9☐Unknown Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obaçco use conti	ribute to th	e cause of death?
ecords,	w requires that been signed I should be det	ted by					1021	res 2□No	3 Prob	ably 4 Unknown
α	The law ate has b page 2 s	Completed					24a. Was autop perfo 1 Yes	rmed?	prior to con death?	osy findings available inpletion of cause of
f Vital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatien	t 2 ER/Outpatier	nt 3 DOA Oth	on	of Death (Check only o		er (Specify	')
on of	Ing Viter		27. Manne Death 28a. Date of Injury 1 atural 5 Pending (Month, Day 2 Accident investigation	Year) 28b. Time of Injury	Wor	yat k? Yes 2 □ N		now injury occurr	red	
Division	l or Attendii after death. Director: A i in by the fu	Certification;	a □ Cuisido — 6 □ Could not be	y - At home, farm, str (Specify)	reet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	er or Rura	l Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical C	29a. Certifier 1 Certifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of and manner state	examination and/or in						
)	To the within 2. To the I complet	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed		
W	P 541		30. Name and address of person who completed cause of de	POST C	Print) FF(ER		OORF M	D. 2	0602
	Sta Registr		31. Date filed (Month, Pay, Year) 5 2005 32. Registral	's Signature	Sperler		· · · · · · · · · · · · · · · · · · ·			

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		м	Decedent's Name (First, Middle, Las	per me G84/	illicate of Deating_2	2. Date of Deat	
	hysici		Riley Alfred Dick			Month	Day Year
1	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	August	12, 2005 5:12 P
			Harford Memorial	Hospital	Havre de Grace		Harford
	ineral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month Day	9. Birthplace (State or Foreign
Dir	ector		212 70 0381 Usual Residence of Decedent	49 Yrs.		Aug. 14, 1	.956 Maryland
land	ehow Mark		10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
Man	r 28a-f ehov	tor	Maryland Cecil	North East			1 ☐ Yes 2 No
et e	or 28e	Directo	10e. Street and Number	NOITH East	10f. Zip Code	10	Dg. Citizen of What Country?
	23a	aiD	110 Michigan Court		21901	1	United States
ae J	E E	Funeral	11. Marital Status	Armed Forces?	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
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Maryland 21215-0036 de 2 should be filed within 72 hours aff this and Mental Hygiene.	vent,	Bec	17. Father's Name (First, Middle, Last)	001101		me (First, Middle, M	
Vente	tic e	ToE	Riley Alford Dicke	ns, Sr.	Anna Pa	uline Pri	.ce
and I	2 2		19a. Informant's Name/Relationship (T	ype, Print) 19b. Mailin	g Address (Street and Number or R	ural Route Number,	City or Town, State, Zip Code)
and and	Important: if item 27 te marked other then "re eny injury or other treumatic event, the Med Once.		Pam Hamilton/Daugh		lichigan Court,No	rth East,	Maryland 21901
Baltimore,	or of		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐		natory or other place) A11011	st 19,	Oc. Location - City or Town, Slate
timen the	Jury		4 ☐ Donation 5 ☐ Other (Specify,	Mayerdale	Crematory 200)5 N	lewark,Delaware
Seperal Seperal	mpor my in		21. Signature of Funeral Service Licens	22.	Name and Address of Facility Cr	ouch Fune	ral Home
_ 40.	2 0 G	LY UTC	There of car	lications that caused the death. Do not enter one cause on each line.	7 South Main Str	eet, North	East, Maryland 21901
Exan	dical niner tial-transit	cai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	a. Atherosclerotic Control Due to (or as a consequence of): b. Due to (or as a consequence of): C. Due to (or as a consequence of):	ardioyascular Dis	sease	
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UIVISION OT VITAI HECORDS, P.O I or Attending Physicien: The law requires that the little death. Director: Alter this certificate has been stoned by the	9 eq	Ď	Cirrhosis of the I	ntributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
0 × 4	201	Completed				4a. Was an	24b. Were autopsy findings available prior to completion of cause of
# # #	page					autopsy perform Yes 2	ed? death?
/ Ita	octor.	Be	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one	
hysic Pisc	al dire	၉	1 Yes 2 □ No	dospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3□ DOA Other: 4□ Nursing H	lome 5 ☐ Residen	ice 6 Other (Specify)
Affer a	nue u	on:	27. Manner of Death 1 XX Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred
ISIC Itend death death	the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No		
Or A or A of A or A or A	io by	T.	4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	el, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	P P	ŭ	29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, death	occurred at the time, date and place	and due to the co-	use/s) and manner as stand
spital	_	B		ner: On the basis of examination and/or inve	estigation, in my opinion, death occu	irred at the time, dat	e and place, and due to the cause(s)
ne Hospital	oletely f	edicai	(Check only 2 Medical Exami one)	and mainter states.			
UIVISION Of VITA To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: Affer this certified	completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exami	and married states.	29c. License number	290	d. Date signed (Month, Day, Year)
To the Hospital within 24 hours	completely f	Medical	one)	ey(ne m)			
To the Hospital within 24 hours	completely f		29b. Signature and title of certifier	e U(vulle M) proprieted cause of death (Item 23a) (Type, P	OCME		gust 14, 2005
To the Hospital within 24 hours.	completely f		29b. Signature and title of certifier	ompleted cause of death (Item 23a) (Type, P	OCME	Au	

446		Please Type or Print in Black State of Maryland / D 1- For Unpend Item 23a,27,28a-f perm 1- Registrar		-	_
Physi		1. Decedent's Name (First, Middle, Last) Mighael Alexious Decling		2. Date of Death Month	Day Year 2 2005 2:00 A M
/Med Exam		4. Facility bloom (Mant institution also stored aumber)	4b. City, Town, or Location of Death		4c. County of Death Cecil
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birt. 213-38-7160 1⊠ M 2□ F 66		8. Date of Birth (Month, Day, Yea June 2, 1	9. Birthplace (State or Foreign Country) Pennsylvania
Maryland f ehow	į	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Cecil	or Location Port Deposit		10d. Inside City Limits 1.☑ Yes 2 □ No
with the ? 3a or 28a-	Funeral Directo	10e. Street and Number 91 North Main Street	10f. Zip Code 21904	10g. (Citizen of What Country?
partitions, in all ylating 212.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantinar mast be notified at	hy Filipers	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Dioroced 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1962-66	13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: White
cthin 72 hove.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work ife. DO NOT use retired)	king Lu	Kind of Business/Industry
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Maryle d 2 should th and Me 27 ie mark traumatic	F	19a. Informant's Name/Relationship (Type, Print)	. Mailing Address (Street and Number or Ru North Main Street,	ral Route Number, Cit	y or Town, State, Zip Code)
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Dallimo	SUC®.	4 Donation 5 Other (Specify) R.A. Fi	erris & Co., Inc. U8/ 22. Name and Address of Facility Lee A. Patterson &		st Chester, Pennsylvania
		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.		or respiratory arrest,	Approximate Interval Between
Physicia /Medica Examine	al	disease or condition resulting in death) Drowning Complication Cardiovascular June Ca	ting Hypertensive At	ner osciero	tic
uted d ansit	Examinar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	of):		
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wrequires that been signed b	2	Part II. Durier significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
The lar	Completed			24a. Was an autopsy performed	
OI VITA Physician: r this certific ral director,	F G	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 EP/Out	tpatient 3 DOA Other: 4 Nursing H		6 Nother (Specify) at scene
anding F wath. or: After	100	27. Manner of Death 1	Time of 28c. Injury at Work? A M 1 □ Yes 2 No	Subject D	
DIVISION To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Cortification.	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify) Scene 29a. Certifier 1 Certifying Physician: To the best of my knowledge	rm, street, factory, office	28f. Location (Street City or Town, St. Near 166 N	and Sumber of Byrai Houte No. 12 ver ate Susquenanna River Main Street Port
ne Hosp n 24 hou ne Fune detely fil	lecipa	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	e, death occurred at the time, date and place d/or investigation, in my opinion, death occu	and due to the cause rred at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
To th To th	Ä	29b. Signature and title of certifier Zulullar AC **	29c. License number O.C.M.E.		Date signed (Month, Day, Year) gust 12, 2005
-		30. Name and address of person who completed cause of death (Item 23a) (
Regi	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2, 2005 4c. County of Death 12:30 A AUG. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Salisbury Nursing and Rehab Center Salisbury, Md. Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2X F 220-32-9082 Director 5/9/1934 Maryland Usuel Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Wicomico Salisbury Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 200 Civic Ave. 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☑ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11 Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fife Department of Health and Mental Hy Important: If Itam 27 Is marked oth any injury or other traumatic event 2008. Duke Weidema Grace Gregg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Davis/daughter 1007 E. Church St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Wicomico Memorial 8/5/05 1 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Park 22. Name and Address of Facility
Holloway Funeral Home Professional Association Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a

Physician /Medical Examiner

with the Maryland

Baltimore, Maryland 21215-0036

ral", or Itams 23a or 28a-f show Exercise nout be notified at

physician and s the burial-transit

signed b

After this

Diractor:

within 24 hours a

Exami Completed by Physician/Medical Be Certification: To

To the Hospital or Attanding Physician: The law requires that the death certificate be executed

Division of Vital Records. P.O. Box 68760.

	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
,	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
	Part II. Other significant con
1	

23c. If yes, outcome of pregnancy
1 Live birth 2 ☐ Fetal deat
4 Pregnant at time of death
9□ Unknown

Due to (or as a consequent of

Due to (or as a consequence of):

3 Ectopic	

23d. Date of de	livery	
230. Date of de	livery	

Reg.

40 as

2 No

art II. Other significant conditions	s contributing to death but not resulti	ng in the underlying cause given in Part I.

23e. Did tobacco us	se con	tribute to t	he cau	se of death?
1 ☐ Yes 2 🖸	31√0	3 🗆 Prot	ably	4 Unknown
24a. Was an autopsy performed?	24b.	Were auto prior to co death? 1 \(\subseteq \text{Yes}	psy fin mpletic	dings available on of cause of

al				2	6. Place of Death (C	heck only one)	
	Hospital:	1 Inpatient	2 ER/Outpatient	3□ DOA Other:	4 4 Hursing Home	5 Residence	6 ☐Other (Specify)
	28a.	Date of Injury	28b. Time of	28c. Injury at Work?	t 28d.	. Describe how inj	ury occurred

lanner of Death Natural Accident	5 Pending investigation	(Month, Day Year)	28b. Time of Injury	M	28c. Injury at Work? 1 ☐ Yes	2 🗌 No	28d. Describe how injury occurred
Suicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stree	et, factor	y, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

		banding, oto. (opouny)			
29a. Certifier	12 Certifying Physic	cien: To the best of my knowledge,	death occurred at the time,	date and place, and	ıd

29a. Certifier (Check only one)	1 ☐ Certifying Physicien: To the best of my knowledge, death of 2 ☐ Medical Examiner: On the basis of examination and/or inversand manner stated.		
29b. Signature and	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM ROBINS	M.D.	200	CIVIC	AVE -	,S&T,ISBURY,	MD.	21804
		- 4					

31. Date filed (Month, Day, Year) AUG 0 4 2005 State Registrar

25. Was case referred to medic examiner?

1 Tyes

27. N

Medical

2 400

Signature States

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day 4.35A M 2005 406057 Daniels Della /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Lanham Doctor's Community Hospital 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2 / 25 / 1918 9. Birthplace (State or Foreign Country)
N.C. **Funeral** Months Days 1 ☐ M 21 F Hours Director 245-58-2132 87 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 le marked other then "natural", or items 23e or 28a-f show other treumatic event, the Medical Exact must be notified at 1 Yes 2 No Directo P.G. Lanham MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 U.S.A. 8200 Goodluck Rd. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: black 3 ₩idowed 4 Divorced Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "natural", eny injury or other treumatic event, IL & Medical Exugate. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Housewife 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Viola Lunford Hill Payton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an Della Huggins/daughter 14008 Town Farm Rd. Upper Marl. MDd20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 8/5/05 Harmony Mem.Pk Landover, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges and Edwards 3910 Silver Hill RD.Suitland, Md. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Betw Innediate Cause (Final disease or condition resulting in death) Onset and Death Alherose Physician levotic YEars. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown ias been signed by i 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ raige ary humas 1 yes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page performed? Yes 2 No 2 No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 No 1 Inpatient 28 ER/Outpatient 3 DOA After this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0

Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) 32. Registrar's Signature

4410

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashai

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lander estille

		Registrar		C	ertificate of Death	Re	eg. No	05 27080
		Decedent's Name (First, Middle, L.	ast)			2. Date of Deat Month	_	3. Time of Death
Physici		MERCED	ES :	DIAZ		August	12, 2	005 3:07 A
/Medic Examir		4a. Facility Name (If not institution, gr	ve street and number)		4b. City, Town, or Location of De	ath	4c. County	of Death
	4	Frederick Memori	al Hospital		Frederick		Fred	erick
Funeral	7-5	Social Security Number 6.		(In yrs. last birthda	y) If Under 1 Year If Under 24 H Months Days Hours M	rs. 8. Date of Birth	Year)	Birthplace (State or Foreig Country)
Director		057-14-2275	1 □ M 2 🛣 F	90 Yrs.	Months Days Hours M.	in. (Month, Day, January 1	1, 1915	West Virginia
P.		Usual Residence of Decedent		10.00				
how		10a. State 10b. County		10c. City, Town or				10d. Inside City Limits
9 Ma	cto	Maryland Freder	Lck	Knoxvi	lle			1 ☐ Yes 2 🛣 No
9 P	Oire.	10e. Street and Number			10f. Zip Code	1	0g. Citizen of	What Country?
be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel", or items 23s or 28s-f show event, the Mudical Examinational the notified at	Funeral Director	2716 Wolfe Drive			21758		U	.S.A.
em a	Ine	11. Marital Status	12. Was Decedent E Armed Forces?		 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 	(Specify Yes or No- erto Rican, etc.)		e - American Indian, ck, White, etc.
afe afe	y FL	1 Never Married 2 Married	1 ☐ Yes 2 😿 No If Yes, Give	0	1 X Yes 2 □ No Specify: S			White
le l	d by	3 Widowed 4 Divorced	Year or Dates:				5,000	
72 7	Completed	15. Decedent's E (Specify only highest g		16a. De (Gi	cedent's Usual Occupation ve kind of work done during most of v . DO NOT use retired)	vorking	16b. Kind of B	usiness/Industry
la l	mpi	Elementary/Secondary (0-12)	College (1-4or 5+	-) //re	Homemaker) II
ygie ygie nt, in								Own Home
is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Manial Hygiene with the Warylan Item 27 is marked other then "neture!", or items 23s or 28s-f show other traumatic event, the Musical Exptring must be notified at	Be	17. Father's Name (First, Middle, Las			18. Mothers N	lame (First, Middle, I	Maiden Suman	10)
should nd Men n marke	2		nso		Teresa		onso	
and and the m		19a. Informant's Name/Relationship			iling Address (Street and Number or			
s 1 end 20 Health Item 27 other tr		Richard Diaz/Son			6 Wolfe Drive, Kn			
of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3	Removal from State	20b. Place of Dis	position (Name of rematory or other place)	Date	20c. Location -	City or Town, State
Pages nent of I		4 Donation 5 Other (Spec		Most Holy	Redeemer Cemetery 08	/16/2005	Baltim	ore, Maryland
permit. Pages Department of Important: If I eny Injury or one		21. Signature of Funeral Service Lice	ensee .at	2 .	22. Name and Address of Facility			East Church Stree
28558		7. Kipin	m=mile	can 1	Keeney and Basford P.A	A. Funeral H		
		23a. Part1. Enter the disease, or con	nplications that caused t		enter the mode of dying, such as card			Approximate Interval Between
Physician		Immediate Cause (Final			. //. 1			Ponset and Death
/Medical		disease or condition resulting in death)		consequence of):	carr and			hours
Examiner			, comp		ast block			hirms
3 3	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):	art block Ischemia			100.00
petr I	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	min	und al	15 chania			hours
y xect end al-tra	xal	resulting in death) Last	Due to (or as a	consequence of):	13CHOP CCA			1000
be ey sicien burial								
phys the	dic		d					
o conficate be executed inding physicien end use as the burial-transit	n/Medicai	IF FEMALE:	23c. If yes, outcome o	f pregnancy			22d Da	te of delivery
atter date		23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at ti	Fetal death	B Ectopic pregnancy Doubler (specify)			nth Day Year
bed bed	Physicia	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	ine or death .	Olifer (specify)			
w requires thet the death been signed by the attershould be deteched for		Part II. Dther significant conditions	contributing to death but	t not resulting in the	underlying cause given in Part I	23e. Did tob	pacco use cont	ribute to the cause of death?
signes I	þ	So, vere dame	nha	,	and onlying subset given in value.	1 🗆 Ye		3 Probably 4 □Unknown
neen neen	tec	Scota Mila				- 1010	3 22110	
law law	ρje	Serve du	sorder			24a. Was a autops	y _	Were autopsy findings available prior to completion of cause of
The The ete h	Completed					perform	ned?	death? I □ Yes 2 □ No
ding Physicien: The lav ding Physicien: The lav n. Atter this certificate has funeral director, page 2	Be (25. Was case reterred to medical examiner?			26. Place of D	eath (Check only on		
ysic ysic dire	10	1 Yes 2 No	Hospital:	t 2 ER/Outpat	ent 3 DOA Other: 4 Nursing	Home 5 Reside	ence 6 Oth	er (Specify)
Ser H Control		27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Time	of 28c. Injury at	28d. Describe ho		
tendin death. for: Aft the fur	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigate		, out,	M 1 ☐ Yes 2 ☐ No			
Attending Physicien: The law requires their the death of death. •ctor: After this certificate has been signed by the atter by the funeral director, page 2 should be deteched for the contraction.	ific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	200. Place of Injur	y - At home, farm,	street, factory, office			er or Rural Route Number,
d in Dig	Certification:	- CHOMINGO	building, etc.	(Spacity)		City or Town	r, Stat u)	
Hospital or Attendi 44 hours after death. Funeral Director: A intelly filled in by the fu	dicai	29a. Certifier Certifying F	hysician: To the best of	my knowledge, de	ath occurred at the time, date and pla	ice, and due to the ca	ause(s) and ma	inner as stated.
	()	(Check only 2 Medical Exa	miner: On the basis of e	examination and/or	investigation, in my opinion, death oc	curred at the time, da	ate and place,	and due to the cause(s)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

610 Ninth

29c. License number

29d. Date signed (Month, Day, Year)

America 1 tentil 29d, per MD, C347, 9/23/05 TIL Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 7:35 P^M VERONICA AUGUST DAVID FLOMO 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ F Yrs. **Director** 220-59-2691 40 June 16 1965 Liberia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumetic event. The Mcdical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠Yes 2 No Directo Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11566 Aldburg Way 20876 Liberia Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ğ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th <u>Nurses Aide</u> Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Richard Davis Vivian Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Germantown, Md. Warnerlyn Becky Warner 11566 Aldburg Way 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens Gate of Heaven Cem. 18-19-05 Silver Spring, Md. 22. Name and Address of Facility 20002 Capitol Mortuary 1425 Maryland Ave., NE Wash.,DC 23a. Part. Enter the disease, or complications that caused the death. Do of enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** AIDS /Medical Due to (or as a consequence of) **Examiner** TOXO PLASMOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) 掛化dd りり Division of Vital Records, P.O. Box 68760, Physician/Medical the as 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a per 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2X No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2X No 2 1X Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide The death occurred at the time, date and place, and due to the cause(s) and manner as stated.

 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier Med 29d. Date signed (Month, Day, Year)

August 5, 2005

Aug. 8, 2005 29b. Signature and title of certifier 29c. License number D0061768 mullis Aug. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fabienne J. Santel, MD

Registrar

State

AUG 0 5 2005

31. Date filed (Month, Day, Year)

3. Registrar's Signature

1500 Forest Glen Road Silver Spring, Md.

20910-1484

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Year **Physician** 5:30 P M 2005 July 31 Gracie C. Ford /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 🗓 F Director May 27, 1914 Maryland Maryland 212-24-4302 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. unt: If item 27 is marked other then "natural", or Items 23e or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State other treumatic event, the Medical Examinar nust be notified at Upper Marlboro 1 XYes 2 No Director Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20772 United States 5412 Old Crain Highway Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 21 No African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Family Care Giver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carrie Stewart 2 James Wesley Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20772 5412 Old Crain Highway, Upper Marlboro, MD Patsy A. Ford Barton/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Importents If eny injury or once. * 4 □ Donation 5 □ Other (Specify) Lincoln Memorial Cem. 8/8/2005 Suitland, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Fun+ral Service Licensee 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1 Ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death on each line. Immediate a se (Final disease or condition resulting in sealth) Physician /Medical Du to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 ☐ No 1 Yes 2 NO Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: 1 Suppatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: 1 Naturai 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide within 24 hours a To the Funerel (Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh 12070 Old Line Louis Kay 20607 31. Date filed (Month, Day, Year, Registrar's Signature State AUG 0 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rag. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2005 Month **Physician** August 2, 8:15 P MARY RUTH FRAZIER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ANNE ARUNDELL MEDICAL CENTER Anne Arundell Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M XXF May 30, 1910 Director Lottsburg.Va 579-03-9729
Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Deperment of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural; or items 23a or 28a-f show any injury or other treumatic event. If a Medical Examinating the radifical anone. 10a, State 10b. County XX Yes 2 ☐ No Directo Upper Marlboro Maryland Prince George's 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 2017 Hancock Drive 20774 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Beautician Self-employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unobtainable Edna Jordan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2017 Hancock Drive Upper Marlboro, Md. 20774
ce of Disposition (Name of Date 20c. Location - City or Town, St <u>Sandra Frazier/great-niece</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 8/6/05 Brentwood, Maryland ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Frazier's Funeral Home, Inc. Natto 389 Rhode Island Ave., NW Wash., DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner andiduria Sequentially list conditions, if any, leading to immediate rause Free Inderlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine as been signed by the attending physicien and a should be detached for use as the burial-transit requires that the death certificate be executed -lostridiva resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant. 3 Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: within 24 hours efter death.

To the Funerel Director: After this certifica funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manne eath 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Sireet and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 05 30. Name and address/of person who completed cause of death (Item 23a) (Type, Print) 2-2 ine 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 4 2005 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 0 5 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** Aug 11, 2005 6:00 pm Fretwell Mildred /Medical 4b. City, Town, or Locetion of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Allegany Cumberland Devlin Manor Nursing Home If Under 1 Year | If Under 24 Hrs.
Months | Deys | Hours | Min. 8. Date of Birth (Month, Day, Yeer) Jun 24, 1912 7. Age (In yrs. last birthdey) 9. Birthplace (Stete or Foreign Deys 1 M 2 F Yrs. 214-05-8050 Usual Residence of Decedent 93 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1□Yes 2□No Cumberland Allegany MD Funeral Director 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 21502 USA 721 Shriver Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐ Yes X ☐ No Specify: 2 x³ ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Business School** 12 supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith Power Stump Samuel D. Stump 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 39 Greene Street Cumberland MD 21502 James Donahue, Jr. attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1√ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/15/2005 MD St. Mary's Cemetery Cumberland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ocute Rend Fallen Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of): Due to (or as a consequence of) resulting in death) Last Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Tyee 2. No 3 Probably 4 □ Unknown advoced COPD

Physician /wiedical Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylend Depertment of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exempted.

attending physician end for use as the bunel-transit signed by the a has been sig ge 2 should b or this certificete has eral director, page 2 or Attending Physicien: efter death. To the Hospital or Attending Physi within 24 hours efter death.

To the Funerel Director: After this completely filled in by the funeral dir

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/Medical Examiner Š Completed 25. Was case referred to medical examiner? Be Certification: To 27. Manner of Death

Hypertolone

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of deeth? 2-No 1 ☐ Yes 2 ☐ No

26. Plece of Death | Check only one Other: 4₽ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 ☐ Yes

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

1 Yes 2 No

1 ANatural

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

00017565

28c. Injury at Work?

1 Yes 2 No

21507

Clug. 11, 2015

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Solleni In N

922 NET1 Hwy LaVZIR

31. Date filed (Month, Day, Year) AUG 1 8 2005 \$2. Registrar's Signature

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

edicai

				State of Ma					-		•	
		•	1 - For State Registrar		,		rtificate of			Reg. No.	2005	27085
	Physicia	an	1. Decedent's Name (First, Middle, Last	1)					2. Date of I Month	Day		
	/Medic	al	BERNICE GATEMAN	and and an about			4b. City, Town, o	ar Location of C	AUGUS		2005 County of Dea	5:10 A M
	Examin	er	4a. Facility Name (If not institution, give 3701 INTERNATIONAL					SPRING		40.		GOMERY
	Funeral		5. Social Security Number 6. Se	7. Ag		last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of I	Birth Day, Year)		rthplace (State or Foreign country)
	Director		130-01-7356	M 2√C]F		85 Yrs.	World's Days	Tiouis	11/28	/1919		CANANDA
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	Mary a-f sh	tor	MARYLAND MONTGOM	ERY			SILVER	SPRING				1 ☐ Yes 2X No
	ith the	Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What C	
	s 23a	eral	3701 INTERNATIONAL	DRIVE #5		S 12 1	Was Decedent of h	20906	2 (Specify Ves or	No.	U.S.	
10	fter de	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2001	,				? (Specify Yes or puerto Rican, etc.)	100	Black, Wh	ite, etc.
036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show kisal Examination must be collified at	ρχ	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No				Specify: W	HITE
5-0	within 72 hours after death with the Marylan liene. I then "natural", or Items 23a or 28a-f show The Madical Examiner must be notified at	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of	working	16b. K	ind of Busines	s/Industry
712	within iene. than "	omp	Elementary/Secondary (0-12)	College (1-4or 5	5+)		EGISTEREI				MEDI	CAL
pc	Hygotha otha	BeC	17. Father's Name (First, Middle, Last)					1	Name (First, Midd	lle, Maiden		
ylaı	Menta Menta arked aric ev	To	ABRAHAM SMOFSKY						SHAPIRO			
Maryland 21215-0036	d 2 short h and 7 Is m traum		19a. Informant's Name/Relationship (TROBERTA G. COHEN/D	• •					ROCKVII			
ē,	tam 2		20a. Method of Disposition		20b. P	Place of Dispo	osition (Name of matory or other pla		Date	-	ocation - City o	
MO	Pages nnt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Other (Specify			-	MORIAL GI	1	5/2005	OLNI	EY, MAR	YLAND
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 Is marked any injury outser traumatic evones.		21. Signatura Funeral Service Licens	S##	,	E	Name and Addre	ess of Facility	ERAL DIR	ECTION	N, INC.	
8	405 a		SAN CHI	lientions that sausa	d the deat		JOI KOCK	/ILLE P	IKE, ROCE	CATPFI	E, MD	20852 Approximate
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final					ng, such as car	rdiac of respiratory	arrost,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. METASTA Due to (or as			ANCER					MONTHS
	Examiner		Sequentially list conditions	b								
	pe sit	Examiner	Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence oi).						
	ie be executed ysician and e burial-transit	хап	that initiated events resulting in death) Last	cDue to (or as	a conseq	uence of):						
760,	m × m	calE		d								
68	eath certificate attending phy I for use as the	Medi	IF FEMALE:									
Вох	ath ce attendi for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Feta	Ideath 3	Ectopic pregnanc	у			23d. Date of do Month	elivery Day Year
o.	by the a	Physician/M	1 Tes 2 No 9 Unknown	4∏Prøgnant a 9∏ Unknown	t time or a	leath 5L	Other (specify) _			-		
Δ.	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	by Pr	Part II. Other significant conditions co	ontributing to death b	out not res	ulting in the u	nderlying cause gr	ven in Part I.	23e. Di	d tobacco u	use contribute	to the cause of death?
Records,	w require been sig should b								15	Yes 2	□No 3□F	Probably 4 Unknown
ecc	law range has be	Completed								topsy	prior to	autopsy findings available completion of cause of
al B									1 Yes	rformed? 2 🔀 No	death?	s 2 No
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatii	ent 2	E9/Outnaties	nt 3 DOA	hor	Death (Check onling Home 50 Re		6 □Other (Sn	ecify)
10		j -	27. Manner of Death	28a. Date of Inju (Month, Da	ury	28b. Time o	1 28c. Inju		28d. Describ			ouny
sior	Attanding I rr death. actor: After by the funer	atlo	1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1	,, , , , , ,	,u.,		Yes 2 □ No				
Division	F # F C	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, et			reet, factory, office			Street an Town, State		Rural Route Number,
	spital ours a neral I		29a. Certifier X Certifying Ph	ysician: To the best	of my kno	wledge, deat	h occurred at the ti	ime, date and p	place, and due to ti	ne cause(s)	and manner a	as stated.
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical		niner: On the basis of and manner st	of examina							
	Withi Comp	Σ	29b. Signature and title of certifier				29c. Licen				te signed (Mor	
	15		Child g	ي ا				2452		AUGUS	ST 3, 2	005
	,		DR. CHITRA RAJAGOP					/E #327	, OLNEY.	MARYI	LAND 2	0832
	Sta		31. Date liled (Month, Day, Year)			F A						
	Regist	rar	AUG 042	005 See	w	5 Kg						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician John Patrick Giblin August 03, 2005 3:00 Рм /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Silver Spring Riderwood Village Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 09/18/1915 Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours Min. 1 X M 2 □ F 577-14-7201 89 Yrs. Pennsylvania Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23a or 28a-1 show the Modical Expedient must be notified at 1 ☐ Yes 2 No MD Montgomery Silver Spring Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 U.S.A. 3160 Gracefield Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status fited within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Duputy Director of Budget Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fife Department of Health and Mental Hy Important: If tiem 27 is marked oth any injury of other traumatic event once. John J. Giblin Elizabeth McDonough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Tester - Daughter 1263 Pine Hill Drive, Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 08-04-2005 Alexandria, Virginia * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral S 1040 Rockville Pike, Rockville, Maryland 20852 Approximate Interval Between Onset and Death Part Carler the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** a Ventricular Arrythmia /Medical Due to (or as a consequence of). Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Sleep Apnea 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 🗆 No 1 Yes 1 Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation М 1 Yes 2 No 2 Accident f Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 9 **Icertif** D24035 08/03/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugenio S. Machado, 3110 Gracefield Road Silver Spring, MD, 20906 31. Date filed (Month, Day, Year) AUG 0 4 32 registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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2005

	ın	1. Decedent's Name (First, Middle,	Last)	_	EBNER	Out.W1	2. Date of I	Death Da		3. Time of Death
/Medica		FLORENCE 4a. Facility Name (If not institution,		GRA	4b. City, Town, or I	Location of D	Death Augu	1	C. County of Dea	
	•		spital		Easton	n			Talbo	+
eral		5. Social Security Number 188-32-9950	1□M 2√FF	(In yrs. last birthday) Yrs.	Months Days	Hours 4	Min. (Month, I	Day, Year) 0	rthplace (State or Fore country)
		Usual Residence of Decedent					SEP 3	, 13	941 PEN	NNSYLVANI
	'n	10a. State 10b. County MD C	AROLINE	10c. City, Town or L	ocation DERSON					10d. Inside City Lim 1 TeyYes 2 □ 1
	Director	10e. Street and Number	ARODINE	11151/11	10f. Zip Code			10g. C	itizen of What C	21
1		160 HENDE	RSON ROAD		2:	1640			USA	
	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of His	spanic Origin n, Mexican, P	? (Specify Yes or I	No-	14. Race - Am Black, Whi	
	by F	1 Never Married 2 Marrie 3 Widowed 4 ∑Divorced	ed 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:	0	1 ☐ Yes 2] No	Specify:			Specify: T	WHITE
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	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retired)		Working			
		1 0 17. Father's Name (First, Middle, L	.ast)		HOMEMAI		Name (First, Midd	lle. Maidei	OWN n Sumame)	
	To Be	STEPH	Clarence M.	Tie1		T	Rita L		,	
once.		19a. Informant's Name/Relationsh		19b. Mail	ing Address (Street ar	nd Number o	or Rural Route Num	ber, City	or Town, State,	Zip Code)
		STEPHEN GRAE	BNER/ SON	20b. Place of Dispo	2 MERGANS	SER R	and the second s	-		
		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation		cemetery, cre	osition (Name of matory or other place natory	- 1	Date	20c. L	Location - City or	
oj.		4 □ Donation 5 □ Other (Sp21. Signature → Funeral Service L	111500	of De	elmarva 2. Name and Address	s of Facility	-4-05		DELMAR	R, DE
9		1 Jugar a	leicher cc	0404	FLEISCHA POB 502	UER_	FUNERAL ENWOOD,	HOM DE	19950	
		23a. Part1. Enter the discussion of shock, or heart failure. List of	complications that caused to only one cause on each line	the death. Do not en	iter the mode of dying	, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
n		Immediate Cause (Final disease or condition	Chronic	1 1 1						
		resulting in death)	a	Obstruct	re pulmi	ongry	disease	e		Onset and Death Yeav S
-			Due to (or as a	Obstruct	rye pulmo	ongry	disease	e		Onset and Death
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DHMH 17 Rev 1/2001

Seen & Sparle

State of Maryland / Department of Health and Mental Hygiene

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			1. Decedent's Name (First, Middle, La	st)						2. Date of Dea		U5 0	-3. Time-of Dea	alb
	Physic /Medi		Ruby	Catherine			Gat	ten	S	Aug	Day	Year 2005	3:15 A	M
	Exami		4a Facility Name (If not institution, giv	e street and number)					lb. City, Town, or i	ocation of Death		ty of Death		_
			Egle Nursing	Home					Lonacon	ing	Alle	gany		
	Funeral Director		5. Social Security Number 6. S 215-20-5837	ex 7. Age ☐ M 2☐ F	(In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da May 12	h y, <i>Year)</i>	9. Birthpla Countr	nce (State or Fo y) yland	preign
	D S to		10a. State 10b. County		10c. City, To	wn or Loc	cation					100	d. Inside City Li	imits
	Mary	to	Md Alleg	any	Bart	on							1 ☐ Yes 21X	ĮΝο
	128 th	rec	10e. Street and Number				10f. Zip	Code			10g. Citizen o	f What Countr	y?	
	13 wit	Funeral Director	19416 Sugar Ma	ple Rd				215	21	ļ	Unite	d Sta	tes	
	8 6	Je.	11. Marital Status	12. Was Decedent Example Forces?	ver in U,S.	13. V	Vas Decede	ent of H	ispanic Origin? (S In, Mexican, Puert	pecify Yes or No-	14. R	ace - Americai lack, White, et		-
21215-0020	within 72 hours after death with the Maryland ane. than "natural", or itema 23a or 28a-f ehow ha Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Nover Married 4 ☐ Divorced	1 Tyes 2 No If Yes, Give Year or Dates:	•	1	☐Yes 2			7 Hour, 616.7	Spec			
5	n 72 hours "natural", cical Ex	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16	a. Deced	ent's Usual	l Occup	ation during most of wor	kina	16b. Kind of	Business/Indu	stry	
121	튙	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			e retired	during most of wor)			_		
	5 4 5 F.		Unknown 17. Father's Name (First, Middle, Last)			Cle	erk		40 Mathada Maa				l Serv	7ic∈
Maryland	ges 1 and 2 should be filed within to Health end Mental Hyglene. If Item 27 is marked other than or other treumetic event, the Me	å							18. Mother's Nan			ame)		
2	d Me d Me d Me d Me	2	Henry Winters 19a. Informant's Name/Relationship (Tuna Print)	11	Ob Mailin	a Addross	/Street	EISIE and Number or Ru	Winter		- Ctata Tis C	Pedal	
∑	47 P		Gary Gattens/S						, Middl				008/	
ē,	of Head		20a. Method of Disposition		20b. Place ceme					Date		- City or Tow	n, State	
e E	Page ent of rt: F		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State		-	-		atory 8	3/10/05	Cumb	orlan	а ма	
Baitimore,	pemit. Pages 1 Dapertment of H Important: if its any injury or ot ange.		21. Signature of Funeral Service Licer			22.	Name and	Addres	s of Facility				a, na	
ã	e o E e o		>7-Ways	& Bol		We	ster	npo	ral Hon	21562		h St		
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused to one cause on each line	he death. De	o not ente	r the mode	of dyin	g, such as cardiac	or respiratory ar	rest,	; 1	Approximate nterval Betweer Onset and Deatl	n
	Physician /Medical		Immediate Cause (Final	/	,		_		,	,		1		
	Examiner		disease or condition resulting in death)	a. Core	6.00	u Sla	les	19	(ciden)	<u></u>			3 week	1/
		5		D	ue to (or as	a consequ	uence of):							
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ó	law requires that the deeth certificata be exacuted as been signed by the attending physicien end 2 should be deteched for use as tha buriel-transit	Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		00 10 (01 00 1	a consequ	once or,					1		
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Вох	attendir for use	Ja Z		d								- !	-	
<u>.</u>	e de the a	Physician/	Part II. Other significant conditions co	ontributing to death but	not resulting	in the un	derlying ca	use give	en in Part I.	23b. Did to	obacco use c	ontribute to t	he cause of de	eath?
P.O.	requires that the di been signed by the should be deteched		Prior Cen	how was in	101 6	10013	las	•		101	es 28 No	3 Proba	bly 4⊡Unk	nown
ds,	res t d b	þ								04-14/		Odb Word	autonou findia	
Š	neen Shoul	ete								24a. Was a perfor	med?	avail	e autopsy findin able prior to pletion of cause	-
of Vital Records,	has h	Completed		-								of de	ath?	
a	£ 2 8		W							104	es 25 No	101	Yes 2□ No	
₹	yaicler is certif directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛪 No	Hospital:	• C = D =			Othe	26. Place of Dea					
	That sales	-	27. Manner of Death	1 ☐ Inpatient	28b	Time of	3□ DOA	c. Injury Work	er: 4 Nursing H	ome 5 Li Resid 28d. Describe h				-
0	the After	힅	1 Natural 5 Pending 2 Accident investigation	(Month, Day)	(ear)	Injury	М		(? Yes 2 □No					
Division	Attending Physicien: ordeath. sector: After this certific by the funeral director.	5	3 Suicide 6 Could not be 4 Homicide determined	286. Place of Injury	At home,	farm, stre	et, factory,	office		28f. Location (S		ber or Rural F	Route Number,	
Ŕ	of Design	Certification:	4 LI Homiciae	building, etc.	(Specify)					City or Tow	n, State)			
	To the Hospital or Attending Ph within 24 hours eiter death. To the Funerel Director: After th complately filled in by the funeral	edicai (29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of a iner: On the basis of ea and manner state	xamination a	je, death nd/or inve	occurred at estigation, i	t the tim in my op	e, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and n late and place	nanner as stat , and due to th	ed. ne cause(s)	
	om pl	ŝ	29b. Signature and title of certifier		7 -		29c.	License	number	2	9d. Date sign	ed (Month, Da	ıy, Year)	
	->-0		1/1/10	18	eli	he	9 1	121	188		8 A	40 7	005	
		-	30. Name and address of person who o	ompleted cause of dea	th (Item 23a	(Type P			100		/	1/2		
		- 4	Dr Thomas Devli					con-	ing Md2	1539				
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar		/	- 10	J.1.	عادات وسد					
	Registr	ar	AUG - 8 2	UUD BOOM	2 10:	135	ONER!							1

	1 - For State Registrar	State of Marylan	id / Depa	artment of F rtificate of	lealth and i <i>Death</i>	Mental Hy	gienę Reg. No.	005	27089
Physician /Medical	Decedent's Name (First, Middle, Last) Ronald	Givens				2. Date of Dea Month July 28,	Day		3. Time of Death 6:15 A.
Examiner	4a. Facility Name (If not institution, give s 5006 Roseld Court			Oxor	r Location of Deat		Pri	County of Death	ge's
Funeral Director	5. Social Security Number 6. Sex 1579–54-0611 Usual Residence of Decedent	7. Age (In yrs. 60		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y, Year)		pplace (State or Foreignity) shington, D.(
or 28a-f show be notified at Director	Maryland Prince Geo		ty, Town or Lo		n Hill		_		10d. Inside City Limit ↑ ↑ Yes 2 □ N
s 23a or 2 must be m erai Dire	10e. Street and Number 5006 Roseld Court			10f. Zip Code	20745		U	zen of What Co J.S.A.	
Depurtment of Health and Mental Hygisne. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any njury or other treumetic event, I'm Medical Exertment by Judited at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, White Specify: B	
ygiene. har than "natur. it, the Medical. Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired Cap Patient	during most of wo. d)	•		nd of Business/I	ndustry reportation
Mental Hygarked other etic event, To Be Co	17. Father's Name (First, Middle, Last) Howard Perr	у				ne (First, Middle, ancy Giver		Sumame)	
m 27 is manar treume	19a. Informant's Name/Relationship (Ty) Mrs. Laurie-Lynn Given	s (Wife)	5006	ng Address (Street Roseld Cou		11, Maryla	nd 2	20745	
tment of H tent: If Ite jury or ot	20a. Method of Disposition **XSBurial 2 Cremation 3 R * 4 Donation 5 Other (Specify)	emoval from State Res	surrecti	osition (Name of matory or other plac on Cenetery	Augus	t 5, 2005	Clin	Real page	yland
Depar Impor any n once	21. Signature of Funeral Service License	maleison	A	2. Name and Addre	ace, N.E.	Washington	1, D.C		
physician and street burial-transit street burial-transit street	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line. Ling Cancer Due to (or as a conseq Atherosclen Due to (or as a conseq Due to (or as a conseq	uence of): otic Car uence of):						Approximate Interval Between Onset and Death Onlins
attending for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnancy	,		2	3d. Date of deli Month	very Day Year
be of	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	ınderlying cause giv	en in Part I.		bacco us		the cause of death?
ate has page 2						24a. Was autop perior 1 Yes	sy	prior to death?	topsy findings available ompletion of cause of
	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpaties 28b. Time of Injury	of 28c. Injur Wor	er: 4 □ Nursing F y at k?	ath (Check only of lome 5 PResidence of Residence of Resi	lence 6	☐Other (Spec	ify)
rs after death. al Diractor: After I ed in by the funers Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, st y)		Yes 2 □ No	28f. Location (S City or Tox		d Number or Ru	ral Route Number,
in 24 hour ha Funare pletely fille edical (29a. Certifier (Check only one) 1 Certifying Phys	sicien: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ation and/or in	th occurred at the tire	me, date and place pinion, death occu	, and due to the orred at the time, o	cause(s) a date and	and manner as place, and due	stated, to the cause(s)
To the comp	29b. Signature and title of certifier 30. Name and address of person who co	mpleted cause of death (Itan	n 23a) (Tvne	29c. Licens	e number D65565			signed (Month	
State Registrar	Michael G. Sidarous 31. Date filed (Month, Day, Year) AUG 0 4 2005		vingsto	n Road #101	Fort Wash	ington, M	20)744	

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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De lawrent Sussex Total Company Delaware Delawar				245-62-2634			Me			24 Hrs. 8 Min.	Date of Birth (Month, Day, 8-28-19		9 Birthr	lace (State or Foreign
Contract		e Maryland 8a-f show ptilied at	ector	10a. State 10b. County Delaware Susses	ζ			on					1	10d. Inside City Limits 1√2 Yes 2 □ No
Contract	•	fler death with the result of	Funeral Dire	158 Central Aver	12. Was Decedent Armed Forces?	Ever in U.S.		19967	spanic Oric n, Mexican	gin? (Specit , Puerto Ric		US 14. P	Race - Americ Black, White,	can Indian, etc.
Contract	12 3-000 C	vithin 72 hours a ne. han "neturel", o	by	3 Widowed 4 Divorced 15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	If Yes, Give Year or Dates: Education rade completed) College (1-4or 5	1963-67	Decedent' (Give kind life. DO I	's Usual Occupa f of work done o VOT use retired	ation	of working	'	16b. Kind of Depart	Business/In	dustry
Physician // Medical Examinor / Due to (or as a consequence of):	ylanu z i	nould be filed w I Mental Hygier narked other th	Be	17. Father's Name (First, Middle, Las George Washin	gton Hamby				Marg	garet	First, Middle, M Gales	Maiden Sum	зате)	
Physician // Medical Examinor / Due to (or as a consequence of):	DIE, Ma	ages 1 and 2 should the stant of the stands		Charlotte Hamby/ 20a. Method of Disposition 1 🖾 Burial 2 🗀 Cremation 3	Wife □Removal from State	20b. Place of cemeter	58 Ce Disposition ry, cremato	ntral A n (Name of ry or other place	venue	e, Mil	llville •	, Dela 20c. Locatio	aware.	19967 own, State
Physician Medical Examiner Dalilli	perrit. Pa Departme Important any Injury		21. Signature of Funeral Service Lie	helen)		Mels West	on Fune	ral S	Service an Vi	es,Ltd Lew, DL	. 199			
The state of the s		/Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)	a. Action Due to (or as	a consequence	of):	Hiluri Bituri Bition	<i>3</i>					Approximate Interval Between Onset and Death
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25. Was case referred to medical examiner? 1	.O. DOX 0	the death certification in the attending I	hysiclan/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal death								•
25. Was case referred to medical examiner? 1	CIUS, T	requires tha been signed I should be det	by	Part II. Other significant conditions ACREMA I	contributing to death by	ut not resulting in	n the under	tying cause give	n in Part I.	_	1 ☐ Ye	s 2 12 No	3 🗆 Prob	abiy 4 ∐Unknown
State 1 Sta	וומו טפר	cien: The lav ertificate has ictor, page 2 (ø	25. Was case referred to medical examiner?					26. Place	of Death (C	autops perform 1 Yes 2	ned? Z No	prior to cor death?	inpletion of cause of
State 1 Sta	A IO HOISI	Attending Physic death. ctor: After this co y the funeral dire	은	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	28a. Date of Injur (Month, Day	ry 28b. T	Time of njury	28c. Injury Work	at	28d	d. Describe ho	w injury occ	urred	
State 1 Sta	Ś	Hospitel or 124 hours after 54 hours		29a. Certifier 1 Certifying F (Check only 2 Medical Exe	building, etc. Physician: To the best of the basis of th	of my knowledge	death occ	curred at the tim	e, date and linion, deat	d place, and	City or Town	, State)	manner as st	ated
State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature		To the within To the Comple	Me	Poto a	Eury) F	Pn4510		DO	number 0 6 1	39.	2	OS	oed (Month, I	Day, Year)
	1	Sta		PETER DI 31. Date filed (Month, Day, Year)	G N Y I	400 ar's Signature	No Le	WOIFE	St.	DA	1.timo	eë, M	<u> </u>	rt 2137

Emma

Lee

Speaks

Heard

1. Decedent's Name (First, Middle, Last)

4:25 P. M

Physician /Medical Exa

Fune Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Madical Estatular main Lea notified at

Baltimore, Maryland 21215-0036

Physicia /Medic Examin

within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	4a. Facility Name (If not institution,			1	Charro							
1	Prince Georges					rly				inc		eorges
		6. Sex 7. Ag	ge (In yrs. last birthda	Month	der 1 Year ns Days	If Under Hours	Min.	Date of Bir Month, Da	v, year)		COL	place (State or Foreigntry)
	579-62-1204	T M 2 A F	83 Yrs.	S	5 54,0	1,00,0	Jı	me 1	6,192	2	Sout	th Carolin
-	Usual Residence of Decedent		1									
	10a. State 10b. County		10c. City, Town or	r Location								10d. Inside City Limit
	Maryland Princ	e Georges	Lando	over								1X Yes 2 □ N
	10e. Street and Number			10f.	Zip Code	•			10g. Citize	n of W	/hat Cou	intry?
	7407 Village G	reen Terrac	e		20785	,			Uni	ted	Sta	ates
-	11. Marital Status	12. Was Decedent		13. Was De	cedent of Hi	ispanic Ori	gin? (Specify	Yes or No				ican Indian.
1	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?	?	If Yes, s	pecify Cuba	ın, Mexicar	i, Puerto Rica	n, etc.)		Blac	k, White	, etc.
	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2 No	Specify:			S	pecify.	B1	ack
	15. Decedent's	Education	16a. De	ecedent's U	sual Occupa	ation	4 = 6 d-i= -		16b. Kind	d of Bu	siness/li	ndustry
Paradilloo	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	life	fe. DO NOT	work done of Tuse retired	during mos f)	t or working					
	9th grade	College (1 40)		nild (Care P	rovid	ler		Do	mes	tic	
	17. Father's Name (First, Middle, La	ast)				18. Mothe	er's Name (Fil	st, Middle,	Maiden S	umam	e)	
2	Washie Spe	eaks				Ca	rrie	Cal	dwell	_		
	19a. Informant's Name/Relationshi	in (Type Print)	10b M	lailina Addre	occ /Stroot	and Numbe	er or Rural Ro	uto Alumbi	ne City ne	Tour	Ctata 7	in Codo)
1												
-	Caroline Tina H	leard (Daugh										land 2077
	20a. Method of Disposition 1 Burial 2 □ Cremation 3	3 Bomoval from State	20b. Place of Dis	isposition (f crematory o	Name of or other plac	(e)	Aug.5,2	2005	20c. Loca	ation -	City or T	own, State
	`4 □Donation 5 □Other (So		George	Washi	ington				Ade1	phi	, Ma	aryland
-	21 Signature of Funeral Se vice Li	· · · · · · · · · · · · · · · · · · ·					_					
	Sandalak	(Hah)	Te	600	N. Hor	ton (Company	Mor	ticia	ns,	Inc	0 20011
1	23a. Part1. Enter the disease, or c	complications the pause	d the death. Do not							ngt	on,L	Approximate
П	shock, or heart failure. List of	nly one cause on each I	ine.				cardiac or res	spiratory a	rrest,			Interval Between Onset and Death
1	Immediate Cause (Final disease or condition	Cancer	of the	null	blad.	der						Onset and Death
	resulting in death)	Due to (or as	a consequence of):	:								
3	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):									
Evaluation	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										- 1	
1	that initiated events resulting in death) Last	C. Due to /or as	a consequence of):									
i		Due to (6) as	a consequence on).	•								
3	U	d										
20												-
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		200					23	d. Date	e of deliv	very
2	in the past 12 months?	4 ☐ Pregnant a		3 ⊟Ectopic 5 ☐ Other	specify)					Mor	nth	Day Year
ñ	9 Unknown	9□ Unknown										
	Part II. Other significant condition	ns contributing to death I	out not resulting in th	ne underlvin	o cause one	en in Part I		23e. Did t	obacco use	a contr	ibute to	the cause of death?
	Personalors.	Carl	701	io unoonym	g oddoo gift	on in and			_			
2		talune						1 🗀	Yes 2□	No	3 🗍 Pro	bably 4 bhknow
2	- CSFITATORY	1	1.								Vara sut	
2	Gastric hernia	ation into	the Ches	st				24a. Was	an	24b. V	TOI O AUL	opsy findings available
5	Gastric hermin	ution into	the Ches	st				auto; perfo	osy ormed?	d	eath?	
in mandillion	Gastric hernic Staphylococcal	1, -	the Ches	st				autor perfo 1 Tyes	osy ormed? 2 X No	d	eath?	opsy findings available ompletion of cause of
fa mondimon on	Gustric herning Stuphy/Ucccal 25. Was case referred to medical examiner?	sepsis			Othe	or	of Death (C)	autop perfo 1 Yes	osy ormed? 2 X No	1	eath?	2 No
for possible property	examiner?	Sepsis Hospital: 1 Hinpati	ent 2 ER/Outpa	atient 3	DOA Othe	er: 4 □ Nu	of Death (C)	autor performance only of Resident Resi	osy ormed? 2 No one) dence 6	1 Othe	eath? Yes	2 No
for moraldimon and as	examiner? 1 Yes 2 100 27. Manner of Death	Sepsis Hospital: 1 Hospital: 28a. Date of Inju	ent 2 ER/Outpa	atient 3	DOA Other	er: 4 □ Nu yat	of Death (C)	autor performance only of Resident Resi	osy ormed? 2 X No	1 Othe	eath? Yes	2 No
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fo paradillocara al	examiner? 1 Yes 2 Ho 27. Manner of Death 1 Matural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no determin	Sepsis Hospital: 1 Impati 28a. Date of Inju (Month, Da 28e. Place of In building, e	ent 2 ER/Outpai ury 28b. Time Injur iury - At home, farm, tc. (Specify)	atient 3 De of Iry M	28c. Injury Work 1 [] 't	er: 4 Nu y at k? Yes 2	or Death /C/ ursing Home 28d. No 28f.	autoperformance autoperformanc	osy 2 No cone) dence 6 how injury Street and wn, State)	Othe	eath? Yes or (Spec.ed	2 □ No ify) ral Route Number,
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 5 2005

2. Registrar's Signature

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			Please 1	Type or Print				_		.egible.	
			For	State of Ma	-		Health and M		-	0.01	0 = 0 = 0
			State Registrar			ertificate of	Death		Reg. No.	<u>UU5</u>	2/092
	Discouling to		1. Decedent's Name (First, Middle, Last					2. Date of De Month	aath Day	Year	3. Time of Death
	Physicia /Medic		John Hopki	ns				July	- 0	15,2005	8:30 am
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City Town,	or Location of Death		4c. (County of Death	
			Mercy Medical	Center		591	Finner				
	Funeral Director		5. Social Security Number 6. Se 033 - 26 - 7187	X 7. Age 7. Age	(In yrs. last birtho	Months Days		8. Date of Bir (Month, Di	rth ay, Year) 11,113	Col	place (State or Foreign intry)
	p.		Usual Residence of Decedent		10c. City, Town o	r I continu					10d. Inside City Limits
	show		10a. State 10b. County MD ANNE AR			ROFTON					1 ☐ Yes 2X No
	e Ma	9	PID ANNE AR	UNDEL							
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show digal Examiner must be notified at	Funeral Director	10e. Street and Number 1668 WICKHAM WAY			10f. Zip Code 21114			-	en of What Cou	intry?
	dea	ner	11. Marital Status	12. Was Decedent E	ver in U.S.	 Was Decedent of If Yes, specify Cu 	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or Ne Rican, etc.)	0- 1	 Race - Amer Black, White 	
5-0036	72 hours after death w "natural", or Items 23a	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	1 TYYes 2 □ No	NKNOWN	1☐Yes 2☐XN					ITE
0-0	2 ho	Completed	15. Decedent's Edu (Specify only highest grad	ucation	16a. D	ecedent's Usual Occi	upation e during most of work	rina	16b. Kin	d of Business/l	ndustry
215	_ * 3	ed l	Elementary/Secondary (0-12)	College (1-4or 5+	11.	fe. DO NOT use retir	ed)	9	00	TITED MICES	W GATEG
217	d with	E O	Elomonial y cooperating (or 12)	2	<u></u>	SELF-EMP	LOYED		GC	VERNMEN	T SALES
2	il Hygi other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden :	Sumame)	
<u>a</u>	lid be fenta ked lic ev	ToE	JOHN A. HOPKINS	SR.			CHRI	STINE M	ACKEN	ZIE	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the M.		19a. Informant's Name/Relationship (T	ype, Print)	19b. M	lailing Address (Stree	et and Number or Rui	al Route Numb	er, City or	Town, State, Z	ip Code)
	od 2 lith a 27 Is		JOHN A. HOPKINS I	II/SON	115	S. CAMER	ON ST. ST	ERLING,	VA 2	0164	
Baltimore,	is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than other treumatic event, Item		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pi		Date	20c. Loc	cation - City or T	own, State
no	0 0 5 5 1		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)				ATORY 7/29	9/05	BRE	NTWOOD,	MD
⋣	permit. Page: Department o Importent: If any injury or once.		21. Signature of Funeral Service Licens		11. 11.						HOME, INC.
Ba	permit. Departr Import any inj		De Course A	TINK							G,MD 20904
		-	23a. Part 1. Enter the disease, or comp	lications that caused	the death. Do not					DI REI	Approximate
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each line	3-1) /	0 - 1 -	0				Onset and Death
	Physician		disease or condition resulting in death)	a. Lett	noed 4:	spiration	Trevmoni	Ε,			1 well
	/Medical Examiner			Ci	consequence of)	1 - /	umonia				
		<u>_</u>	Sequentially list conditions,	b. Due to (or as a	ASP 17		010001114				
	ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oi	izea!	Cutanear	3 Fisty	9			
	and and Il-trar	xan	that initiated events resulting in death) Last		oensequence of)		1,3,0				
60,	be executed ician and burial-transit	-		Lange	ngeal	Cancer					
687	phys the	ol o	•	d	00.1						
O. Box 6	e death certificate be execut the attending physician and ned for use as the burial-trar	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of the complete of the co	2 ☐ Fetal death	3 Ectopic pregnar 5 Other (specify)	icy		2	3d. Date of deli Month	very Day Year
σ.	requires that the de een signed by the a hould be detached	Ph	Part II. Other significant conditions co	ontributing to death bu	t not resulting in the	he underlying cause of	uven in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
Vital Records,	m D 0	by	Tartii. Otilor signiilottii ootistisii oo	on the down of	t not pooling in t		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1/2	Yes 2	No 3□Pro	bably 4 Unknown
orc	w require been sig should b	Completed									
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<u> </u>	The ate	Son						1 ☐ Yes	2 No	death?	2□ No
ia	i cien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	one)		
₹	Q: 50	To	1 Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/Outp	atient 3□DOA	Other: 4 - Nursing H	ome 5 Res	idence 6	Other (Spec	cify)
οr	ding Ph h. After th funeral	Ë	27. Manger of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tir Year) Inje		jury at fork?	28d. Describe	how injury	occurred	
.0	Attanding r death. ector: After by the fune	atle	2 Accident investigation			M 1	□Yes 2□No				
Division	octo by th	tifle	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ry - At home, farm	n, street, factory, offic	е	28f. Location City or To	(Street and own, State)	Number or Ru	ral Route Number,
Ö	tel or Attandii s after death. al Director: A ed in by the fu	Certification:		Sunding, oto	. ,						
	Hospi 4 hour Funer ely fill	Medical (29a. Certifier 1 Certifying Ph (Check only one) Medicel Exem	ysicien: To the best of niner: On the basis of and manner sta	exemination and/	death occurred at the or investigation, in m	time, date and place y opinion, death occu	, and due to the rred at the time	e cause(s) o, date and	and manner as place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	11. 11	#	29c. Lice	nse number		29d. Date	signed (Monti	Day, Year)

30. Name and as

> D0061952 of death (Item 23a) (Type, Print) St. Paul Pl.

Balt, MD 21202

31. Date filed (Month, Day, Year) State Registrar

AUG 0 4 2005

ess of person who completed of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Day 30, Ju1y 2005 12:30 P.M Hyman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mt. Airy Frederick Kline Hospice House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 3, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Days Hours Director 1924 Washington, D.C 578-22-0731 81 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-f show any high of the traumatic event, the Medical Event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits X□Yes 2□No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 2404 Graystone Lane U. S. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑X'es 2 □ No If Yes, Give WW 2 Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Private Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lillian Rosenberg Louis Hyman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2404 Graystone Lane, Frederick, Maryland Helen Hyman - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State King David Mem Garden 8/2/2005 Falls Church, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
1091 Kockville Pike, Rockville, Haryland 20852 tottlemer 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death 2 Months Immediate Cause (Final **Physician** Adenocarcinoma of the Lung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Lymphocytic Leukemia 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 😿 No To the Hospital or Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ Nursing Home $_{5}$ Residence $_{6}$ Nursing Home 2 1 ☐ Yes X☐ No 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? X Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Diractor: A filled in by the fi investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 1, 2005 D31761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian M. O'Connor, M. D. 501 W. Seventh Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) gistrar's Signature 32.1 State

Registrar

2005

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	Dhinisi	, in .	Decedent's Name (First, Middle, La.					2. 0	ate of Death	Day Year	3. Time of Death
	Physici /Medic	al	Mialametia	Hepler	· · · · · · · · · · · · · · · · · · ·	4.00 7			ıgust	8 2005	
1	Examin	er	4a. Facility Name (If not institution, give Southern Marylar			4b. City, Town, c		of Death		4c. County of Dea Prince (
	Funeral	於	5. Social Security Number 6. S	ex 7. Age (Ir	n yrs. last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. C	ate of Birth	9 Bir	tholace (State or Foreign
12	Director		578-70-8202	□M 210 F	53 Yrs.	Worters Days	riours	A	pril 3,	1952Was	hington, D.C.
)	/land		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation					10d. Inside City Limits
	B Mar	ctor	Maryland Prince	Georges	Clinton	n					1 AYes 2 No
	vith th	Directo	10e. Street and Number			10f. Zip Code				Citizen of What C	-
	ne 234	Funerai	7111 Firebrush C	12. Was Decedent Eve	r in U.S. 13. \	20735		gin? (Specify		United S	
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itama 23s or 28s-f show sumatic event, the Muckal Extension count to milling at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:	1	f Yes, specify Cub 1 ☐ Yes 2 ☒ No	an, Mexican	i, Puerto Ricar	n, etc.)	Specify: B1	te, etc.
2	72 ho natur	eted	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	oation during most	t of working	16b	. Kind of Business	/Industry
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	Paralega				OPM- Go	vernment
<u>1</u> 2	Hygi other	Be Co	17. Father's Name (First, Middle, Last)	<u> </u>		14141080		er's Name (Firs	st, Middle, Maid		VOLIMOITO
Vlar	Menta Menta arked	To B	Lawrence Hepler				Beu	lah Tr	uitt		
Nan	12 sho h and 7 is my		19a. Informant's Name/Relationship (ty or Town, State,	Zip Code)
ۇ ر	1 and Healti Iam 27		Genaro M. McCau		20b. Place of Disno	Jniversit		Waldo:	7	20602 Location - City or	Town, State
Ē	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Resurrect	natory or other pla tion		ug.17,	2005 C	linton, l	Md.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic av		21. Signature of Funeral Service Licer		085					Homes, P	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the						1110, 114	Approximate Interval Between
2. c.	Physician		tmmediate Cause (Finat disease or condition resulting in death)	a Complicat	tions of	sickle co	ell_an	nemia			Onset and Death
**	/Medical Examiner		resulting in deality	Due to (or as a co	onsequence of):						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	onsequence of):						
	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
8760,	cate be executed physicien and the burial-transit		resulting in death, East	Due to (or as a co	onsequence or):						
687	ificate g phys as the	edicai		_ d							
Box	leath certifica ettending ph I for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome of p		Ectopic pregnanc	у .			23d. Date of de	
0	requires that the death certific een signed by the ettending p hould be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 ØNo 9 □ Unknown	4□Pregnant at time 9□Unknown	e of death 5	Other (specify)				Month	Day Year
مذ	res that the de signed by the e be detached f	by Ph	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.		23e. Did tobaco	co use contribute to	o the cause of death?
rds	w requires been sign should be								1 🗌 Yes	2 No 3 P	robably 4 Unknown
ecc	¥ 4 8	Completed							24a. Was an autopsy	24b. Were a	utopsy findings available comptetion of cause of
a H								1	performed Yes 2□		2 □ No
Ĭ	s certil	To Be	25. Was case referred to medical examiner? 11℃ Yes 2 □ No	Hospital: ↑ ☐ Inpatient	2 X ER/Outpatien	t 3D DOA Ott	205	of Death (Ch		6 □Other (Spe	north)
פֿר	Attanding Physician: r death. sctor: After this certificion the funeral director,		27. Manner of Death	28a. Date of Injury (Month, Day Ye					Describe how in		c.iy)
Sior	Attendir death. ctor: Af y the fur	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	1		M 1	Yes 2 □				
Division of Vital Records,	= 9 = 7	Certification:	4 Homicide determined		- At home, farm, str Specify)	eet, factory, office			ocation (Street City or Town, St		ural Route Number,
	Fu F	edicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of m niner: On the basis of exa and manner stated	amination and/or in	n occurred at the ti vestigation, in my o	me, date and opinion, deat	d place, and d th occurred at	lue to the cause the time, date	e(s) and manner a and place, and due	s stated. e to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. Licens	se number		29d.	Date signed (Mont	th, Day, Year)
)			Thodoe !	. Kind	up	OCI	Œ		A	ugust, 9	, 2005
f	_		30. Name and address of person who THE COORE M. King		r (Item 23a) (Type, Penn Sti		imore	, Md.	21201		
200	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 2 2005	32. Registrar's	Signature	w w					

			For 1_ State			yland / De	partment of F	lealth and	Mental Hyg	0.0.				
		10/	Registrar 1. Decedent's Name (First, Mid	dle, Last)			erinicate of	Death	2. Date of Deat	_	3. Time of Death			
	Physici /Medio		Richard	L.		Jewell		Sr.		Sey 2005	5 10:22AM			
	Examin	er	4a. Facility Name (If not institute Memorial Hos		and number)		4b. City, Town, o	or Location of Dea	ith	4c. County of De				
	Funeral		5. Social Security Number	6. Sex 1 → M 2	□ E	(In yrs. last birthd	Months Days	If Under 24 Hrs Hours Mir		Allegany	rthplace (State or Foreign Country)			
	Director		213-36-0579 Usual Residence of Decedent	XM	6	9 Yrs			Nov 3,	1935	MD			
	aryland show	_	10a. State 10b. Coun	neral		10c. City, Town or	t Ashby				10d. Inside City Limits			
	the Ma 28a-f	recto	10e. Street and Number				10f. Zip Code		1	0g. Citîzen of What 0	1 Tyes 2 No X			
	ours after death with the Marylan 'al', or Itams 23c or 28a-f show Examiliat roust be mutified at	Funeral Director	P.O. Box 681					26719		USA				
	Itams	nne	11. Marital Status 1 □ Never Married 2 □ Married 2 □ Married	Arı	as Decedent Ev med Forces?	er in U.S. 1	 Was Decedent of H If Yes, specify Cub 	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Art Black, Wh				
036	ours af	þ	3 Widowed 4 Divorce	od If Ye	⊒Yes 2∏No Yes, Give X ear or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	hite			
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. ad other than "natural", or Itams 23a or 28a-f show event, Its Madical Exacilinat right to natified at	Completed	(Specify only high			(G	cedent's Usual Occup ive kind of work done b. DO NOT use retire	oation during most of wo	orking	16b. Kind of Busines	s/Industry			
2	filed withi Hygiene. Ither than	Somp	Elementary/Secondary (0-12 12	Co	oilege (1-4or 5+)		puter Prog		i	Social Sec	urity			
and	ould be file Mental Hy arked oth atic event	Be	17. Father's Name (First, Middle Carson Jew						ame (First, Middle, M	Maiden Surname)				
Maryland	2 should be and Menta Is marked sumatic ev	ဥ	19a. Informant's Name/Relatio	nship (Type, Pr	rint)	19b. M	ailing Address (Street		Kessell J	Jewell er, City or Town, State, Zip Code)				
	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		Richard Jewel	l Jr. 	son		21 Rosalie sposition (Name of crematory or other pla		Baltim		/ID 21234			
altimore,	00		20a. Method of Disposition 1 ☐ Burial 2 ☐ ★remation 4 ☐ Donation 5 ☐ Other		7/29/2005	20c. Location - City o								
altir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service		101	100	Funeral Home	ass of Facility		Cresaptov	vn MD			
8	Dep Imp any onc		23a. Pari1. Enter the disease, shock, of heart failure. Li	lli Funeral I ginia Avent	Home, PA u e: Cumberl	and, MD 215	63							
			immediate Cause (Final	st only one cau	is that caused tr	10 40 LG	enter the mode of dyll	ng, such as cardia	L'a	est,	Approximate Interval Between Onset and Death			
僵	/Medical		disease or condition resulting in death)	a	Due to (or as a	conservence of):	rollar o	mar	colon					
	Examiner	Į.	Sequentially list conditions,	b	Due to (on as	consequence of):	ion							
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	【 。_ `	Cox	mary	Mellitus	y dis	ense					
760,	ate be executed nysician and he burial-transit		resulting in death) Last		Due to (or as a	consequence of	114 11 15 c	, T						
687	ificate I g physi as the t	edlcal		d	13100	11000	M Cany M.	s 11		1				
Вох	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		yes, outcome of □Live birth 2	Fetal death	3 □Ectopic pregnanc	у		23d. Date of de Month	elivery Day Year			
0.	at the dea by the al	ysici	1 Yes 2 No		□Pregnant at tii □Unknown	me of death	5 ☐ Other (specify) _			Monar	Day Teal			
S, P	es that igned b	by Pr	Part II. Other significant cond	tions contributi	ing to death but	not resulting in th	e underlying cause giv	ven in Part I.			to the cause of death?			
Records,	w require been si should t										Probably 4 Unknown			
SPOON of the part of the part 12 months? 1														
		BeC	25. Was case referred to medie examiner?					26. Place of De	1 Yes 2 eath (Check only on		s 2□No			
of V	this ald dir	ို	1 Yes 2 No	Hospita	1 LI Inpatient	2 Le R/Outpa 28b. Tim	Hent 3L DOA			nce 6 Other (Sp.	ecify)			
	Jing After fune	atlon	1 Matural 5 ☐ Pend	ling tigation	a. Date of Injury (Month, Day	/ear) Injui	y Wo	rk? Yes 2□No	20d. Describe no	w injury occurred				
Division	or Attendater death Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be mined 28e	e. Place of Injury building, etc.	/ - At home, larm, (Specify)	street, factory, office		28f. Location (Str City or Town	reet and Number or Rural Route Number, , State)				
	To the Hospital or Attuwithin 24 hours after de To the Funeral Direct completely filled in by the		29a. Certifier 1 ☑ Certify	ing Physician:	: To the best of	my knowledge, d	eath occurred at the til	me, date and place	e, and due to the ca	use(s) and manner a	s stated.			
	the Ho in 24 h the Ful pletely	ledical	(Check only 2 Medic	al Examiner: O	n the basis of e	xamination and/o	r investigation, in my o	opinion, death occ	curred at the time, da	ite and place, and du	e to the cause(s)			
	With To T	Σ	29b. Signature and title of certi	10 0	Maria.	har	29c. Licens	se number V 16 41 -	_	7 29 05				
			30. Name and address of person	n who complete	ed cause + ea	th (Item 23a) (Ty	De, Print) POP CENT	V 10 7 1	0-	, 2103	2.0			
			VIJAMK Cr 31. Date filed (Month, Day, Yea	DWDH	ARY I	MD 57	14 CENT	ER AVE	= KOMIN	EH W.	26+17			
	Sta Registi		AUG]	8 2005	Resea	w St.	Sparke							

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Registrar

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			1 - For State Registrer	State of Marylan		artment of H			ene BNG AAE	27007
П			1. Decedent's Name (First, Middle, Last)				2. Date of Death	2003	-3. Time of Death
	Physici /Medic		SARA F. K	AHN				JULY 28,	Day Year 2005	1:15pм
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deatl	n	4c. County of Death	
			3114 GRACEFIELD RI		((SILVER S			MONTGOMER	
	Funeral Director		5. Social Security Number 6. Se 215-01-8059	TA 200 E	9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1	Year) 9. Birth	place (State or Foreign Intry)
١.			Usual Residence of Decedent	0	9			11/21/19	MAK)	ZLÁND
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	B-fs	ctor	MARYLAND MONTGOME	RY SILV	ER SPR	ING				1 X Yes 2 □ No
	or 28	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	ath w	rail	3114 GRACEFIELD RI			2090			U.S.A.	
	ltems	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
50	hours after death with the Maryland tural', or Items 23a or 28a-f show at Exaciding 1.	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: T	VHITE
9500-6121	n 72 hours after death with the Marylar "natural", or Items 23a or 28a-1 show colled Exa. illust is ust be notified at		15. Decedent's Ed	ucation	16a. Deced	dent's Usual Occupa	ation	10	6b. Kind of Business/li	
7		Completed	(Specify only highest grad	College (1-4 or 5+)	(Give	kind of work done o DO NOT use retired	during most of wor l)	rking		
N.	e filed within I Hygiene. other than rent, Ire M	Con	12	,	HOMEM	AKER			OWN HOME	
Maryland	m - 0 2	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, Ma	aiden Sumame)	
<u>\</u>	should be nd Menta marked matic ev	ဥ	HYMAN FRIEDMAN				BESSIE H			
Mai	d 2 st h and 7 la n traun		19a. Informant's Name/Relationship (T)						City or Town, State, Zi	
ص ص	1 and Heall am 2		BENJAMIN L. KAHN/I	20b. F	Place of Dispo	sition (Name of	1	_	R SPRING, N	
20	ages in to d	- 8	1 X Burial 2 ☐ Cremation 3 ☐ I 14 ☐ Donation 5 ☐ Other (Specify,	Removal from State	emetery, crer	natory or other plac		_		
Baltimore,	artme ortan injur		21. Signature of Funeral Service Licens						DELPHI, MA	RYLAND
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury of other traumatic evonce.		1 (manda	Kudeura	ED 10	WARD SAGE	EL FUNERA	AL DIRECTI	ION, INC. LLE, MD 208	25.2
r	4		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deat						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a CARDIAC ARRY						Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq						
	Examiner		Sequentially list conditions.	b. ASTHMA						
	sit ed	Examiner	Sequentially list conditions, if any, leading to familiar cause. Enter Underlying Cause (Disease or injury	Dué to (or as a sunseq	uanca bi):					
	and and Il-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):					
8/60	cate be executed physician and the burial-transit				,,.					
200	certificate be executed nding physician and ise as the burial-transit	edicai		d						
ROX	leath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		1 			23d. Date of deliv	ery
	0 0	sicia	in the past 12 months? 1 Yes 2 No	1 Live birth 2 Feta 4 Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
r Ö	at the de by the a	Physici	9 Unknown	9 Unknown						
-	requires that the een signed by th nould be detache	by	Part II. Other significant conditions co		ulting in the u	nderlying cause give	en in Part I.		cco use contribute to t	
ord	w require been si should I	ted	MITRAL REGURGITAT					1 L Yes	2 □ No 3 □ Pro	bably 4 <u>X</u> JUnknown
Hecords	₹ □ □	Completed	ALZHEIMERS DISEASI	<u> </u>				24a. Was an autopsy	prior to co	ppsy findings available impletion of cause of
	t: The icate his		OSTEOPOROSIS WITH	COMPRESSION F	'RACTUR	ES		performe 1 ☐ Yes 2X	ed? death? □ No 1 □ Yes	2□ No
Vital	Physician: The la this certificate has ral director, page 2	o Be	25. Was case referred to medical examiner?	Hospital:		_ Othe		th Check only one		
O	Phy r this ral d	 -	1 ☐ Yes 2 🗶 No 27. Manner of Death	1 □ Inpatient 2 □	ER/Outpatien 28b. Time of	t 3 DOA	4 ☐ Nursing H	ome 5 X Residen 28d. Describe how	ce 6 Other (Speci	fy)
0	th. : After e funer	atior	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work	<br Yes 2 □ No		,,	
UIVISION	I or Attending after death. I Director: After d in by the fune	ifice	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (Stre	et and Number or Run	al Route Number,
5	tal or A s after al Dire	Certification:	Litomode	building, etc. (Specif	у)			City or Town,	State)	
	To the Hospital of within 24 hours at Fo the Funeral Documental Completely filled in	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best of my kno iner: On the basis of examina	wiedge, death	occurred at the tim	ne, date and place	, and due to the cau	se(s) and manner as s	itated.
	To the Hos within 24 h To the Fur completely	Medi	0.110)	and manner stated.						
	To To	-	29b. Signature and title of certifier	Attender	MAD	29c. License		290	d. Date signed (Month,	Day, Year)
	5	9	John ?	rucky	1110	D2364	19		JULY 30,	2005
)	l li	30. Name and address of person who c	1.1			מיידיתים מי	1 MADS7* 433	m 2000/	
	Sta	te	JOHN STUCKEY, M.D. 31. Date filed (Month, Day, Year)	2. Registrar's Signa	ituro -		TV DLKTING	, MAKILAN	D 20904	
	Registr		AIIG 0 4 200	E L		Te D				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 05 Day Month **Physician** RICHARD RAYMOND KITZMILLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HEART OHQU Cumberland
If Under 1 Year | If Under 24 Hrs. HILLEGAN Accec 8. Date of Birth Month, Day, Yo JUNE 19, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace State or Foreign **Funeral** Days Months Hours Year) 1973 1**X** M 2□ F MARYLAND 217-88-6718 32 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show ir than "natural", or itams 23a or 28e-f showing Wedical Examinations be notified at 1 X Yes 2 ☐ No MD GARRETT MT. LAKE PARK Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 B STREET 21550 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No δ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) othar than Elementary/Secondary (0-12) College (1-4or 5+) NEVER WORKED N/A or other traumatic avent, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked othing any injury or other traumatic avent <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM E. KITZMILLER LOUISE RIDDER ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LOUISE KITZMILLER - MOTHER 112 B ST. MT. LAKE PARK, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State OMEGA CREMATORY * 4 ☐ Donation 5 ☐ Other (Specify) 8/12/05 MORGANTOWN, WV 21. Signature o Funera 22. Name and Address of Facility P.O. BOX 243 olu M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cerebral **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 days Sersis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a dorse ouence of) Examiner The law requires that the death certificate be executed the burial-transit ding physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 🗆 No or Attanding Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Mpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Director: After 1 Anatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seton Drive, Cumberland, MD 21502 IKramadit 31. Date filed (Month, Day, Year) AUG 1 32. Registrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For Stete Registrer	State of Mary		partmen ertificate			and M		iene	005	27099
	Physici	an	1. Decedent's Name (First, Middle, Las	*						2. Date of Dea Month AUGUST	-	20 05 °	3. Time of Death
	/Medic Examin	al	ELIZABETH L. K. 4a. Facility Name (If not institution, give WILLIAM HILL MA	e street and number)			Town, or	Location o	of Death	AUGUST	<u> </u>	2005 unty of Death TALBO	
	Funeral Director		5. Social Security Number 6. S 155-09-8690		yrs. last birthday			If Under Hours	24 Hrs. Min.	8. Date of Birth SEPT 18	^Y 1916	9. Birth	place (State or Foreign Print) YORK
	ytand now		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or I	Location							10d. Inside City Limits
	the Mar 28e-f el	ector	MD TALB	OT	EAS'		Code				On Citiens	-1.07	XXYes 2 No
	3a or	l Dir	9538 BLACK DOG A	LLEY D7		10f. Zip	216	01		1	og. Citizen	ol What Cou	intry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "neturel", or items 23a or 28e-f ehow may injury or other traumatic event. The Midical Examinar must be nutified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S. 13	I. Was Deced If Yes, spec	lent of Hi		gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White	
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d 21	filed wi Hygien other th	0	8 17. Father's Name (First, Middle, Last)	0	CHEC	K PROC	ESSC		er's Name	e (First, Middle, i	BANK Maiden Sun		
Maryland	should be and Mental marked o	ToB	ABRAHAM MASON					LAI	JRA (OLSEN			
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altin	permit. Pag Department Importent: I any injury o		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer		CHESAPEA					6/3/2009 1 & NEWN			
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	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	onsequence of):	iste	200	sclo	m				zán
8760,	ate be executed thysician and the burial-transit	Ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):								
.O. Box 6	Attanding Physicien: The law requires that the death certificate be executed refath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pri					23d.	Date of deliv Month	ery Day Year
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21. Signature of Fuheral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 3a. Parti Effect the disease, or complications that caused the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Industrial Island Control of Island Islan]c	Crem	matic					ova	al fr	rom	Sta	te	20	C	em	eter	y, ci	ema	tory	or	oth	her p	plac				_ ,					20c.							
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Douglas Van Zoeren, M.D. 1101 N. Capitol St., N.E. Wash., DC 20002																				to	01	L	St		.]	Ν-	Ε.	W:	asl	1	_ D	С	200	002					

		•	For State Registrar	State of Ma	arylan	d / De _l	partment of ertificate of	Health and f Death		Reg. No.		27101
	Physici /Medio		1. Decedent's Name (First, Middle, L	sen					2. Date of D	-10 Day	- 200:	3. Time of Death 6:30 AM
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	show		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or	Location					10d. Inside City Limits
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	th with t	al Dir	10e. Street and Number 62 East Stoney I	Run			10f. Zip Code	75		U	zen of What Co	untry?
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jeal Examiner must be malified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 反 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		.S. 1	3. Was Decedent of If Yes, specify Co 1 ☐ Yes 2 ☑ N		Specify Yes or N rto Rican, etc.)		14. Race - Ame Black, Whit Specify: W	
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ج 2121!	filed within 7/ Hygiene. other than "n ent, It with a	dmo	Elementary/Secondary (0-12)	College (1-4or 5	i+)		nical Eng			Brev	wery structi	on
	should be filed nd Mental Hygi marked other matic event,	BeC	17. Father's Name (First, Middle, Las	st)					ame (First, Midd	le, Maiden	Sumame)	
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DOD - Baltimore,	Page nent c ant: # ury or	1 7	1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other Spec 21. Signature of Fun 1 Service	cify)	Cap	e Her emato	*	8-1	1-05	_	nkford,	Delaware
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	Physician		23a. Part1. Enter the disease, or co shock, or heart failur. List on Immediate Cause (Final disease or condition resulting in death)	a. MU	Inc	h. Do not		ying, such as cardi				Approximate Interval Between Onset and Death ALMS
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ا محرا 0. Box 6	attending for use	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	death	3 □Ectopic pregnar 5 □ Other (specify)			2	23d. Date of del Month	ivery Day Year
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Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune fune.	Certification:	3 Suicide 6 Could not determine		ury - At ho	ome, farm,	street, factory, office	е	28f. Location City or T	(Street and own, State)	d Number or Ri)	ural Route Number,
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	To the within 2 To the complet	M	29b. Signature and title of certifier	Higgi	~)/	MO		onse number ((DE)		e signed (Mont	h, Day, Year)
	6		30. Name and address of person wh	N,MO 12	39 C	DAST	AL HIGH	WAY, F	ENWIC	16 15	SLAND	DE 4944
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	ars Signa	Rure	Gode					
D	HMH 17 Rev 1/2	94	AUG 1 8	2005 Lien	150	DO 1	HOW WALL					

ORIGINAL

		4	ForState	State of Mar	yland /		rtment of H			giene Reg. No.	05	27103
			Registrar 1. Decedent's Name (First, Middle,	(act)			imouto or i	-	2. Date of De			3. Time of Death
	Physicia			Luster					July 2	29, Day 20	05 ^{Yeer}	6:40A M
	/Medic	al	Viola S. 4a. Facility Name (If not institution,				4b. City, Town, or	Location of Dea			nty of Deeth	
	Examin	Ç.			Con	tar	Cheve			Prin	ice G	eorges
agi Si.			Prince George 5. Social Security Number	S HUSPICAL	In yrs. last	birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Bir	th		plece (State or Foreign intry)
	Funeral Director		579-44-7084	1 □ M 2 🙀 F	102	Yrs.	Months Days	Hours Min	Sept.	10, 19	902	Alabama
- 4	i jay sii		Usual Residence of Decedent									10d. Inside City Limits
-	how		10a. State 10b. County	1	10c. City, T							11⁄2 Yes 2 □ No
	Ba-f	cto	Md. P.G.		Cap	ito.	l Height	CS		10g. Citizen	of What Co.	
3	or 24	Dire	10e. Street and Number				10f. Zip Code 20743	2		Unite		
	death with the Maryland	Funeral Director	526 Opus Aver			12.1			(Specify Voc or No		Race - Amer	
	er de	nue	11. Marital Status	12. Was Decedent Ev Armed Forces? d 1 ☐ Yes 2 ☑ No		13.	Was Decedent of H f Yes, specify Cuba	an, Mexican, Pue	erto Rican, etc.)	E	Black, White	
9	hours after tural', or Ite	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1		1 ☐ Yes 2X No	Specify:		Spe	B1	ack
21215-0036	tura tura		15. Decedent's	Education	1	6a. Dece	dent's Usual Occup	ation	- drin -	16b. Kind of	f Business/I	ndustry
<u>င</u>	nn 72	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+))	life.	kind of work done DO NOT use retired	during most of w	vorking			
212	filed within 72 Hygiene. other than "natent, ina Medic	Completed	Unknown	Oonego (1 101 0 1)	<u> </u>	Do	mestic			Priv		
<u>o</u>	m - 0 5	Bec	17. Father's Name (First, Middle, L						lame (First, Middle		iame)	
<u>a</u>	should be nd Mental marked c imatic eve	2	Junius Smi	th					e Rowel			
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone.		19a. Informant's Name/Relationsh			19b. Mailii 526	ODUS AV	and Number or Cenue		9279		ip Code)
≥	and ealth m 27		Joyce Johnson	/daughter	20h Plac	Capi	Opus Av to 1 He i	ghts,	Marylar	10 20 20c. Locatio) 7:43	Town, State
ore ore	Tiof H		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	3 □Removal from State	cem	etery, cre	matory or other plac	1				
Baltimore,	tmen tant:		`4 □Donation 5 □Other (Sp		Ceda		ill Ceme 2. Name and Addre				land,	
a a	Depar Depar Mpor Mpor Iny ir		21. Signature of Funeral Service L	Consee	1-							Md.20746
	40244		23a. Pary . Enter the disease, or o	complications that caused t	he death.						rana,	Approximate
			shock, or heart failure. List of Immediate Cause (Final	niy one cause on each line).). A		RDIAL					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a			NUME	710 7 411 0	77670			
	Examiner			RENAL	FAI	LUR	E					
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequer	nce of):						
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С								
o Î	te be executed ysician and ne burial-transit	Ex	resulting in death) Last	Due to (or as a	consequer	nce of):						
3760,		ical		d								
89 ×	ing pl	Med	IF FEMALE:	02a Huga autaama	d prognance	.,			.,	024	Date of dol	
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at t	Fetal de	eath 3	□Ectopic pregnanc □ Other (specify) _	у		23u.	Date of deli Month	Day Year
O	the a	ysic	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	9 Unknown	ille oi deal	51	_ Other (specify) _					
P.O.	that the	-P	Part II. Other significant conditio	ns contributing to death bu	t not resulti	ng in the t	underlying cause gr	ven in Part I.	23e. Did	tobacco use o	contribute to	the cause of death?
ds,	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	Completed by Physician/Medi	ADVANCED DEN	ENTIX					_ 10	Yes 22X(N	o 3□Pr	obably 4 Unknown
So	w requir been s should	lete							24a. Wa		4b. Were au	topsy findings available
Re	The lay	μğ							– auto perf 1 ☐ Yes	opsy formed? 2 🗷 No	death?	completion of cause of 2□ No
Ta			25. Was case referred to medical					26. Place of I	Death (Check only			
⋽	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 K Inpatier	nt 2 EF	NOutpatie	nt 3 DOA	her: 4 Nursin	g Home 5 ☐ Res	sidence 6 🗆	Other (Spe	cify)
10			27. Manner of Death	28a. Date of Injury (Month, Day	y Year) 2	8b. Time o	of 28c. Inju	ry at	28d. Describe	how injury oc	curred	
<u>o</u>	Attending of death. ector: After by the fune	atlo	1 Natural 5 Pending	ation				Yes 2 □ No				
Division of Vital Records,	I or Attendater death Director:	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi			e, farm, s	treet, factory, office			(Street and No own, State)	umber or Ru	ural Route Number,
Ω	Hospital or the hours afte Funeral Dir tely filled in			Division Table had	d mustemanul	-d d	th annumed at the !	ima data and pl	ace, and due to the	a causa(s) and	d manner as	hateta
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifyin (Check only 2 Medical 1	g Physician: To the best o Examiner: On the basis of and manner stat	examinatio	n and/or i	nvestigation, in my	opinion, death o	ccurred at the time	, date and pla	ice, and due	to the cause(s)
	within To the	Me	29d. Date signed (Month)									
	60	1	1	//			D5	8182		7-	29-	05
	(A)		30. Name and address of person		ath (Item 2	(Type	Print)	e	CHEVER	/\/ A.A	D 121	185
	SC		DR C. DONALD C		300/		TIAL SA		CHEVEN	1-101	,	100
	St Regist	ate trar	31. Date filed (Month, Bay Year)	Blow -	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Wesley Edwin Arnold Lewis July 30 2005 1:06 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Suburban Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 213-11-5697 11 1922 Guyana 83 January Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or items 23e or 28a-f show Examiner must be notified at 1X Yes 2 No MD Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2210 Greenery Lane # 201 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural', or 1 ☐ Yes 2√ No Specify: ģ Specify Black. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Police Officer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herbert Lewis Princess Isaacs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Frances A. Lewis/Wife 2210 Greenery Ln # 201 Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 8/4/05 * 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Silver Spring, Maryland 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Embolism /Medical Due to (or as a consequence of): Examiner Left Hip Fracture Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of): Examiner The taw requires that the death certificate be executed Diabetes Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hypertension the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Parkinson's Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 24 No 1 Yes 2XX No 1 Yes Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 2 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 No 4-2005 2 Accident investigation -al 10me Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 28f. 4 | Homicide Resideni SILVER MO 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medi within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D 15736 August 1, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carl Margolis MD 11125 Rockville Pike Rockville, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 0 4 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

			For	State of Marylan					lental Hy	giene	/ / / · · · · · · · · · · · · · · · · ·	_		
			1 - State Registrar Amend #10a 10		Ce	rtificate	of Dear	th		Reg. No	2005	27	105	
	Physicia	an	Decedent's Name (First, Middle, Las						2. Date of D Month	Day			e of Death	
	/Medic		Joseph Richard Mo			4b. City, To	own, or Location	on of Death	July		2005 County of Dea		12 P M	
	LXAIIIII	Ci Ci	Gladys Spellman Sp		tal		sville			i	rince G		3	
	Funeral		Social Security Number 6. Security Number	TYM 2016	• • • • • • • • • • • • • • • • • • • •		Year If Und	der 24 Hrs.	8. Date of B (Month, D			rthplace (Sta		
¥.	Director		Usual Residence of Decedent	88	Yrs.				11/06/	1916	Nor	th Car	colina	
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation						10d. Inside	City Limits	
	a-fat	ctor	N/A D.C. N/A	- 1	Washin	gton,	DC					1図)	′es 2 □ No	
	or 28	Director	10e. Street and Number			10f. Zip C				10g. Cit	izen of What C	ountry?		
	e 23e		4503 4th NW	10 11 0 1 1 5	2 142	200					U.S.A.			
	ter de	Funeral	11. Marital Status 1 □ Never Married 2 🔯 Married	12. Was Decedent Ever in U Armed Forces? ★★Yes 2 ☐ No	.S. 13.	If Yes, specify	nt of Hispanic y Cuban, Mexi	Origin? (Spe ican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi		1,	
Š	ai', or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WWI	I	1 ☐ Yes 2	No Spec	eify:			Specify: B1	ack		
2	72 hc	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual	done durina n	nost of worki	n q	16b. K	ind of Business			
7	within ane. then	idui	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)							
2	Hygie Hygie other		17. Father's Name (First, Middle, Last)		Opera	ting E	nginee		(First, Middle		Sumame)	gricul	ture	
Ö	fental fental rked tic av	To Be	Richard McCre	e			E	lizabe	th Uno	btair	nable			
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or itame 23a or 28a-f ahow important: If them 27 is marked other than "natural", or itame 23a or 28a-f ahow any injuny or other traumatic avent, the Madical Examinar must be notilled at once.		19a. Informant's Name/Relationship (7	ype, Print)							or Town, State,	Zip Code)		
, 2	and 2 eelth m 27 her tr		Alice McCree/Wife		1		W Wash:			-				
2	Pages 1 nent of H ant: if ita ary or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cre	matory or oth	er place)		ate		ocation - City or		9	
	artmer artmer ortant injury		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen				emetery				ntwood, Funeral			
0	permit. Departr imports any inju		Vart.	Tel e							d, MD 2			
(j. 1 € -2			23a. Part1. Enter the disease, or composition, or heart failure. List only	olications that caused the deat							•	Approxir	nate Between	
	Physician		Immediate Cause (Final disease or condition		Fod 1	**							nd Death	
	/Medical Examiner		resulting in death)	a. Respiratory Due to (or as a conseq										
	- Adminior	-	Sequentially list conditions,	b	Anoxic Encephalopathy Due to (or as a consequence of):									
	uted J ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Data to (or as a consequence or).										
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5	death certifica attending plant for use as t		IF FEMALE:	220 If you and amount of any										
2	w requires that the death cer been signed by the attendir should be detached for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d	Ideath 3	☐Ectopic preg ☐ Other (spec					23d. Date of de Month	livery Day	Year	
į	t the d by the ached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown										
, O	gned be det	by P	Part II. Other significant conditions of		ulting in the u	inderlying cau	ise given in Pa	art I.	23e. Did	tobacco u	use contribute t	o the cause	of death?	
5	requir een si bould	ted	Persistant Veget						1 🗆	Yes 2	□ No 3 □ P	robably 4	⊠Unknown	
ה ה	e taw has b	Completed	Cerebral infarct	ions						opsy	24b. Were a prior to death?	utopsy findin completion (gs available of cause of	
2	n: Th ficate rr, pag		Insulin Dependan	t Diabetes Mel	llitus				1 ☐ Yes	ormed? 2⊠No	1 Yes	s 25No		
5	eicia s certi	To Be	examiner? 1 Yes 2 1 No	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outpation	nt 3 DOA	Cthar	_	(Check only		6 □Other (Spe			
5	ig Phy ter thi neral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		: Injury at Work?		28d. Describe			эспу)		
	andin eath. or: Af	atlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М	1 Yes 2	□No						
2	or Att	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ruccity or Town, State)										lumber,	
_	spital ours a nerel l	al Ce	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as											
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within £4 hours alter death within £4 hours alter death. To the Funstel Director: Alter this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stored one)											
	To the To the comp	M	29b. Signature and title of century	Se. s.		29c. I	License numb	er		29d. Dat	te signed (Mon	th, Dey, Year	r)	
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2	(5)		30. Name and address of person who alles, MD				Landon	or M	יפלחכ ח	5				
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State Registrar 31. Date filed (Month, Day, Year)

AUG 0 4 2005



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Dorothy Lee McDowell 27, Ju1y 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 213 Kettering Drive Upper Prince Georges Marlboro 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 200 F Yrs. **Director** 579-54-4840 NC 1940 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23a or 28e-f show the Medical Examiner must be nutified at Md. P.G. Upper Marlboro 1√2 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 Kettering Drive 20774 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 Ž☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 1 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filad within h and Mental Hygiene 7 Is markad other then "r Elementary/Secondary (0-12) College (1-4or 5+) DC Government <u>Administration</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If tiem 27 Is marked any injury or other traumatic events. James N. Flowers Sr. Lizzie L. Todd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Kettering Drive Valerie L. McDowell/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20774 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem. Cem. 8/1/05 ' 4 ☐ Donation 5 ☐ Other (Specify) Landover, Md. 21. Signatore of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OVARIAM **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine inding physician and usa as the burial-transit Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 moeths? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sir 1 Tes 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 Yes 2**X** No Division of Vital ours after daath. erel Diractor: After this certific filled in by tha funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 4 Nursing Home 5XX Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel Completely filled 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature aportitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of the ath (Item 23a) (Type, Print) COLIN OTTE 8601 MARTIN LUTHER thery LANHAM, MD MD 31. Date filed (Month, Day, Year) 32. Registrar's S State AUG 0 4 2005 Registrar

Aaggett		1 - For Unpend Item 2	State of Marylan 23a,pt.II,27 p	d/Depa er me	artment of F	lealth and Deathas	d Mental Hy	giene Reg. No.2 ()	05 27	107
Dhista		1. Decedent's Name (First, Middle, Last)				2. Date of Dea		Year 3. Tim	ne of Death
Physici /Medic		Roy A.	Magget	t			August	00	2005 18:	:12
Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o		eath		nty of Death	
		Southern Maryland 5. Social Security Number 6. Se		last hirthday)	CL1:	nton If Under 24 H	Irs. 8. Date of Birt	h	ce George'	
Funeral Director			©M 2□F 6.	• • •	Months Days		Nov. 8,	y, Year) 1941	Chicago,	_
pu ,		Usual Residence of Decedent		-						
laryla ehov	ř	10a. State 10b. County		y, Town or Lo						de City Limits Yes 2 ☐ No
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deatl	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No lerto Rican, etc.)	14. R	ace - American India	n,
or its		1 Never Married 2 Married	1X Yes 2 □ No If Yes, Give		1 ☐ Yes 2X No	Specify:	ieno riican, etc.)		lack, White, etc. hify: Black	
hours ture!	ed by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	162 Dagg	dent's Usual Occup	ation				
nin 72 n na	plet	(Specify only highest grad	College (1-4or 5+)	(Give	kind of work done of NOT use retired	during most of v 1)	working	160. Kind of	Business/Industry	
d with giene	Completed	Elementary/Secondary (0-12)	College (1-401 5+)	Orth	opedic Te	chnicia	an	_ Priva	ıte	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatle and Mental Hygiene. Important: If teem 27 is marked other than "naturel", or iteme 23s or 28s-1 show eny injury or other traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (T) Patricia Maggett					Rural Route Number Roanoke		n, State, Zip Code) N.C. 278	370
s 1 and t Heal		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other place		Date	20c. Location	n - City or Town, Stat	:e
Page nent of nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Tellioval Both State	ropol:			,13,2005	Alexan	dria, Va.	
rmit. spartm ports y inju		21. Signature of Funeral Service Licens	9	22	Name and Addre	ss of Faculty	e Funeral	Homes	. P.A.	
Beans C		1 Detha	Dung MO10	85	5538 Marl	boro Pi	ke/Forest	ville,		47
		23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the death se cause on each line.	n. Do not ent	er the mode of dyin	g, such as card	fiac or respiratory ar	rest,	Approx Interval	imate I Between and Death
Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	a Renal Diseas						Oliser	ind Death
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be executed sician and burial-transit	EX	resulting in death) Last	Due to (or as a consequ	uence of):						
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death a atter d for u	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	<u>, </u>		The second second	ate of delivery Month Day	Year
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es that igned t	by F	Part II. Other significant conditions co					23e. Did to	obacco use co	ntribute to the cause	of death?
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ect e	o Be	25. Was case referred to medical examiner? 1 🗓 Yes 2 🗌 No	Hospital: 1 ☐ Inpatient 2 🔀	ER/Outpatien	t 3(7)004 Oth	00	Death (Check only o			
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To the Hospital or Attending within 24 hours after death of To the Funeral Director: Alte completely filled in by the fune	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or in	occurred at the ting vestigation, in my o	ne, date and pla pinion, death o	ace, and due to the o courred at the time, o	cause(s) and n date and place	nanner as stated. , and due to the cau	se(s)
To the Within To the	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date sign	red (Month, Day, Yea	ar)
		· auat2			(O.C.M.E.		August	09, 2005	
		30. Name and address of person who co	ompleted cause of death (Item				1			
		ANA RUBIO	32 Panistrada Ciri			eet, Bal	ltimore, N	arylan	a 21201	
Sta Registr	_	31. Data Aug 1 2 2005	32. Registraris Signal	parti	•					

05-05387 DONALD K MORRIS WHM **Physician** /Medical Examiner **Funeral** Director Maryland 28a-f ehow other traumatic event, if a Mudical Examiner must be notified at Directo ö 238 or iteme Baltimore, Maryland 21215-0036 ģ "naturel", Completed marked other than 2 should be fi and Mental h Be permit. Pages 1 and 2 s
Department of Health an
Importent: If Item 27 is
eny injury or other trau

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. unpend item#23a, 27, 28a-f, permE, G846, 8/24/05 IT State of Maryland / Department of Health and Mental Hygiene 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 AUGUST 9, 1:06 P M DONALD KEITH MORRIS 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dealh ST MARYS CO LEONARDTOWN ST MARYS HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 SAY 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min XIXM 2□ F Yrs. OCT.6,1952 214-60-2641 WASH. D.C Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND ST. MARY'S MECHANICSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25820 HILLS DRIVE 20659 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2X XIo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes XXNo Specify Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SALES REPRESENTATIVE NABISCO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOSEPH MORRIS LAURA CRIM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BRENDA CAMPBELL - SPOUSE 25820 HILLS DRIVE, MECHANICSVILLE, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2000 remation 3 Removal from State 4 □ Donation 5 □ Other (Specify) METROPOLITIAN CREMATORY 8-13-05 ALEXANDRIA, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 on one enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one eause on each line. Immediate Cause (Final disease or condition Oxycodone intoxication resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1

Yes 2 □ No autopsy performe 1 Yes 2□ No 25. Was case referred to medical 26. Place of Death Check Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 X DOA 1 XYes 2 □ No 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury Findfonth, Day Year) unk 1 Natural 5 Pending 1 Yes 2 No investigation 8/9/ 2005 12:07 PM 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rufal Route Number City or Town, State) 25820 Hills DR determined 4 - Homicide Scene Mechanicsville, MD 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification:

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certified

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 1 8 2005

y frank

29c. License number

OCME

111 PENN STREET, BALTIMORE, MARYLAND, 21201

29d. Date signed (Month, Day, Year)

AUGUST 10, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 5:55 P M WILLIE MAE NICKENS August 2, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5526 Tinkers Creek Place Prince Georges Clinton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🛛 F 54 **Director** 223-78-7460 04-01-51 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other then "naturel", or Items 23e or 28a-f show other traumatic event, the Medical Examinar must be notified. Maryland Prince Georges Clinton 1 XYes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5526 Tinkers Creek Place 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married XXMarried Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2000 Specify à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Human Resource Manager Utility - Wash. Gas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fill and Mental H Be Versie Sebree Lawrence Pope 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5504 Rockfish Way, Clinton, MD 20735 Latosha Nickens/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery 08-08-05 Clinton, MD 4 Donation 5 Other (Specify) 20735 21. Signat (re) of Funeral S 22. Name and Address of Facility Strickland Funeral Services, 6500 Allentown Rd., Camp Springs, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Plasmoblastie **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 3 years Examiner Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician requires that the death certificate be Physician/Medicai IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq Division of Vital Records, Known Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 Yes 2 No Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 No 2 funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Director: After Hospitel or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal and manner stated within 2 29b. Signature and title of certifier Physician 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reservoir Rd NW Washington PC Ekatherine Asatiani 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

State

Registrar

AUG 05 2005

			State of Ma	•	ertificate of I	lealth and Me		000	
			Registrar		eruncate or i		Reg.	NOZ 11115	27 10
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н			Wicomico Nursing Home 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthda)) If Under 1 Year	If Under 24 Hrs. 8	. Date of Birth	9 Birthi	place (State or Foreign
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	or 20	Dire	10e. Street and Number		10f. Zip Code			Citizen of What Cou	ntry?
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23s or 28e-f show any injury or other treumatic svent, I'm Medical Examinar must be intiffed at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Yes 2 ☒ H 1Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	can, etc.)	Black, White,	, etc.
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	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other then "neturel" or items 23a or 28a-f show or other treumatic event, the Medical Exertinal must be multified at	Funeral	Armed Forces?		f Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)	Black, White	
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2	and ealth m 27		Helen Rogovsky, Spouse						yland 20781
0	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tree		20a. Method of Disposition 1 □ Burial 2 ② Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crei	natory or other place))	4	. Location - City or	
Ē	tment tent: jury		* 4 □ Donation 5 □ Other (Specify)		n Crematory				Virginia
Baltimore,	permit Depar Impor any in		21. Signature of Funeral Service Licenden		2. Name and Address				
	40 = 6 Q		Alle May	4	739 Balti	more Ave	nue, Hyati	tsville,	Maryland Approximate
			23a. Part 1 Enter the disease, or complication that caused the shock or heart failure. List only one cause on each line.	2 AS A	er the mode of dying,	such as cardiac c	or respiratory arrest,		Interval Between Onset and Death
	Physician		Immediate/Cause (Final disease or condition resulting in death)	AKDIKC	ARRHYTH	MIA			
В	/Medical Examiner		Due to (or as a c	consequence of):					
В		_	Sequentially list conditions, b. Due to lor as a c	consequence of:					
	ed sit	ulne	cause. Enter Underlying Cause (Disease or injury						
	death certificate be executed e attending physician and of for use as the burial-transit	Examiner	that initiated events c. Due to (or as a c	consequence of):					
8760,	be e sician buria	dicai E							
687	ficate physis the	edic	d.						
Box (leath certifica attending ph I for use as tl	Physiclan/Me	IF FEMALE: 23c. If yes, outcome of 23b. Was decedent pregnant					23d. Date of del	ivery
	atter of for	clar	in the past 12 months? 4 Pregnant at tin		⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>			Month	Day Year
o.	that the de ed by the detached	Jysi	9 Unknown						
۵.	requires that the een signed by th hould be detache	by PI	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause giver	n in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
rds,	w requires that s been signed t should be det						1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
00	> Q 0	ompleted					24a. Was an	24b. Were au	topsy findings available
Re	9 4	E					autopsy performed 1 ☐ Yes 2 🛣	l? death?	completion of cause of
of Vital Record	i cian : Th certificate ector, pag	O	25. Was case referred to medical			26. Place of Death	(Check only one)	101 100	2010
>		OB	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient	2 ER/Outpatie	Other	~	me 5 Residence	6 ☐Other (Spe	cify)
	g Physer this seral di	H.	27. Manner of Death 1 Natural 5 Dending (Month, Day)	(ear) 28b. Time o	f 28c. Injury		28d. Describe how i	njury occurred	
Division	Attending ir death. ector: After by the fune	atlon:	1 X Natural 5 Pending (Month, Day Y 2 Accident investigation (Month, Day Y	oa.,,a.y		es 2 □No			
Vis	of or Attendate after death Director: /	ti Ei	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	· At home, farm, st (Specify)	reet, factory, office		28f. Location (Stree. City or Town, S.		ural Route Number,
	tel or s afte el Dir	Certific		(-,,)					
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of Check only 2 Medical Examiner: On the basis of each						
	To the H within 24 To the F complete	ledical	one) and manner state			· · · · · · · · · · · · · · · · · · ·			
	To To	Σ	29b. Signature and title of pertifier		29c. License	,		Date signed (Mont	
•	<u></u>	1	1007		25%	142		8-2-	- 05
0	17)11		30. Name and address of person who completed cause of dea				1	8-2-	2008=
	1119	-	DR KEITH BONIFACE	300/ Hos Signature	SPITAL B	*	CHEVER	LY MO	20700
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's	s Signature					
	Regist	di	AUG 0 5 2005	A ASS					

		For State Registrar	. 10400	State o	f Marylar	nd / Depa <i>Cei</i>	rtment tificate					Reg. No	2005	27	112
Physi		1. Decedent's Name (First Eric	, Middle, Las. Lione	,	dolph						2. Date of De Aug. 1		5 Year	3. Time 6:37	of Death M
/Med Exam		4a. Facility Name (If not in Civista Med			mber)		46. City, T LaPla		Location of	Death			County of Dea arles	th	
Funera Directo		5. Social Security Number 105–54–8447	6. Se	x X 2 F	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D. 10/04)	ay, Year)	9. Bir Co Ala	thplace (State ountry) abama	e or Foreign
aryland show	'n		_{County} harles		10c. C	ity, Town or Lo						-			City Limits
th the M or 28a-f	Olrecto	10e. Street and Number				Waldel	10f. Zip					10g. Citiz	en of What C	_	
death w	erai [21 Keepsake	Place	12. Was Dec	edent Ever in l	U.S. 13.	_ 1	206		in? (Spe	cify Yes or N Rican, etc.)	0- 1	U.S.	ərican Indian,	
2-UU30 72 hours after of natural', or Iter alea Examina	by Funeral Director	1 Never Married 2		Armed Fo 1 ☐ Yes If Yes, Gi Year or D	ve XNo		1 Yes, speci		Specify:	, Pueno i	rican, etc.)		Black, Whi	Black	
CLESSON STATES AND SO THE CONTROL OF THE MATCH AND THE MAT	Completed	(Specify onf	-	ucation de <i>completed)</i> College ((Give	tent's Usual kind of work DO NOT use ole Te	k done di e retired)	uring most	of workii	ng	16b. Kin	of Business Privat		
BAITIMORE, MISTYIANG ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28a-1 show any injury or other traumatic event, Item inclined in the mast inclined.	Be	12th 17. Father's Name (First, Oscar Rudo							18. Mother		(First, Middle				
Mary I	7	19a. Informant's Name/R Toney Ma			n		•				Route Numb		Town, State,	Zip Code)	
ore, I		20a. Method of Dispositio	n mation 3 🗆	Removal from	20b. State	Place of Dispo	sition (Nam natory or ot	e of her place	9)	0	ate	20c. Los	cation - City or		
Saltimore, bernit. Pages 1 a Department of Hes mportant: If them any injury or othe	ġ	4 Donation 5 0	Other (Specify	1)	T	rinity	Cemet 2. Name and)8/05 'Fre			dorf, M Services	ary⊥ar	nd
	5500	23a. Part Lenter the dis	ease, or com	dications that	caused the dea					land,	Marylar	nd 207		Approxim	nate
Physicia /Medica	al	shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	re. List only	a.Co	oach line.		hear	<i>t</i> _	Fai	lus	<			Interval E Onset an	nd Death
Examine		Sequentially list condition if any, leading to immedia cause. Enter Underlying	ns, ate	b. Due to	(or as a conse	equence of):									
3 / 60, ate be executed nysician and he burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last		cDue to	(or as a conse	equence of):									
Box 687 leath certificate attending phys		IF FEMALE:		. d.											
. 0 0 0	Physician/Med	23b. Was decedent preg in the past 12 montl 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 Live	utcome of preg birth 2 ☐ Fe inant at time of nown	ital death 3[⊒Ectopic pro ⊒ Other (sp					2	3d. Date of de Month	Day	Year
dS, P.	ğ	Part II. Other significant	conditions	ontributing to	death but not re	esulting in the u	nderlying c	ause give	en in Part I.			tobacco u	se contribute	to the cause of	
Records, P.O. The law requires that the ate has been signed by the age 2 should be detached.	Completed										per	opsy formed?	prior to death?	utopsy findin completion o	gs available of cause of
Vital Rec ician: The law certificate has	Be Co	25. Was case referred to examiner?	medical	11				0#		of Death	1 ☐ Yes 1 (Check only			5 20 140	
hys this	lon: To		Pending	28a. Date (Mo.		28b. Time of Injury		8c. Injury Work	4 🗆 140		me 5 Res 28d. Describe		Other (Sp	ecity)	
Division of a or Attending Patter death. Director: After I in by the funers	Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not b	e 28e. Plac	e of Injury - At ding, etc. (Spe	home, farm, st cify)					28f. Location City or To	(Street and own, State)	d Number or F	Rural Route N	lumber,
To the Hospital or within 24 hours affe To the Funeral Dir completely filled in	edical C	29a. Certifier 1 (Check only 2 one)	Certifying Ph Medical Exar	miner: On the	ne best of my k basis of exami nner stated.	nowledge, dea nation and/or in	th occurred evestigation	at the tim	ne, date an pinion, dea	d place, th occurr	and due to the	e cause(s) e, date and	and manner a place, and du	is stated. le to the caus	e(s)
To the To the Comple	Me	29b. Signature and title of	of dertifier.	olell	Λ)		-522					e signed (Mor	-	r)
(2)		30. Name and address o Nalin Math						. 40	4, Wa	.1dor	f, MD	2060)3		
	State istrar	31. Date filed (Month, Da	ay, Year)	32.	Registrar's Sig	nature									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 6:57 P DAVID RUBINSTEIN August 02 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1/€M 2□ F Months 84 Yrs Director 5<u>34-14-5863</u> Dec. 04 1920 Germany Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County items 23a or 28e-f show Irer must be notified at 1 Yes 2 No Completed by Funeral Director MD Potomac Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code 11017 Seven Hill 20854 United States Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturelt, or lies any injury or other treumatic event, Item Maclical Estation 2 No WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3- Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Statistician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leo Rubinstein Dora Ascheim 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael Rubinstein, Son 2209 Cold Meadow Way Silver Spring MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1
Burial 2 □ Cremation 3 □ Removal from State King David Mem Grdns | 08-04-2005 | Falls Church, VA * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service 11800 New Hampshire Ave Silver Spring MD 20904 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on comblications that caused the death. Do not enter the mode of dying, such as cardiac or a spiratery arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 🗌 Yes 2 No 1 Yes 20 : After this certifical funeral director, I To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending Injury 1 TYes hours after death. investigation Director: 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide within 24 hours a filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Near) 29b. Signature and title of certifier 0 08 58484 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salim Aziz, M.D. 11119 Rockville Pike Suite 100 Rockville MD 20852-3143 31. Date filed (Month, Day, Year) State 2005 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 15, 2005 11:29AMM Mary Virginia Rudy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Homewood at Crumland Farms Frederick 8. Date of Birth Month, Day (Month, Day 6, 1913 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 6. Sex 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2√2 F 91 Mary Land 217-10-9724 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits item 27 is marked other than "natural", or Itema 23s or 28a-1 shov other traumatic event, the Madical Examiner must be notified at Maryland Frederick Frederick 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 7407 Willow Road U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White ₩Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Be Richard Stanley Keyser Mary Rebecca Salter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Health a Mrs. Judy C. Horman, daughter 5649 Horman Lane, Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State jo 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Mount Olivet Cemetery August 17, 2005 Frederick, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Reeney and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prrysician a consequence of): disease or condition resulting in death) Odas /Medical Due to (or a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a msequence of) Examiner burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MIOM autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Tes 2 No Certification: To 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 12 Natural 5 Pending 4 hours after death. death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lettifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical and determined in the desired in the kind whedge, death occurred at the time, date and place, and due to the cause(s) and maintenance as states.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and maintenance as states.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and maintenance as states. (Check only one) within 2 29b. Signature and title Acertifier 29c. License number 29d. Date signed (Month, Day, Year) D 16428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Casper E. Cline III, M.D., 300 West Ninth Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) State AUG 1 8 2005 Registrar

			State of Maryland / Den	artment of Health and Mental Hygiene	ic.
			Togotto	rtificate of Death Rag. No 2 1 1	5 27115
	Physicia		1. Decedent's Name <i>(First, Middle, Last)</i> Della England Reynolds	Month Day Y	ear 9:45 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of	-3
			Calvert Manor Healthcare Center	Rising Sun Cecil	
I	Funeral Director		5. Social Security Number 213-05-5991 Usual Residence of Decedent 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthday 94 Yrs.	If Under 1 Year If Under 24 Hrs. Min. Months Days Hours Min. Nov • 8 , 1910 Min. Months M). Birthplace (State or Foreign Country) laryland
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or the Florida Collier Everglace		10d. Inside City Limits 1∑Yes 2☐No
	s with the 3a or 28a If be noti	I Direc	10e. Street and Number 411 Copeland Avenue	10f. Zip Code 10g. Citizen of Wh 34139 United S	
136	be filed within 72 hours atter death with the Maryland tal Hygiene. Advised than "natural", or items 23a or 28a-f ahow do other than "natural", or items 23a or 28a-f ahow avant, the Madral Examinar must be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 🖾 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 🖰 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black,	American Indian, White, etc. White
Maryland 21215-0036	be filed within 72 hould Hygiene. Id other than "nature avant, the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 16a. Dec (Giv Giv Ife.) Secret	ident's Usual Occupation skind of work done during most of working DO NOT use retired) tary United S	Government
land 2	should be filed with nd Mental Hygiene. marked other than imatic avant, the N	To Be Co	17. Father's Name (First, Middle, Last) Cloud England	18. Mother's Name (First, Middle, Maiden Sumame) Flora May Mason	
	is 1 and 2 should of Health and Men itam 27 Is marke other traumetic	•	1 1 1 1	ing Address (Street and Number or Rural Route Number, City or Town, St Bouchelle Road Elkton, Maryland	21921
Baltimore,	Pages 1 and the nent of He int: If itam			matory or other place) August 6	ity or Town, State Ist, Maryland
Balti	permit. Pages Department of Important: If it any injury or o			2. Name and Address of Facility 127 South Main Frouch Funeral Home North East, Ma	
	nysician /Medical Examiner		23a Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,		Approximate Interval Between Onset and Death
	filcate be executed physician and as the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that imitated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):		
.O. Box 68	death cert e attending d for use a	Physiclan/Med		□Ectopic pregnancy 23d. Date Other (specify) Monti	
rds, P	w requires that s been signed b should be deta	b	Part II. Other significant conditions contributing to death but not resulting in the		oute to the cause of death? Probably 4 Unknown
al Records,	The ta ate has page 2	Completed		autopsy pri performed? de	ere autopsy findings available or to completion of cause of ath?] Yes 2 X No
Z Z	nysician: Th nis certiticate director, pag	o Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only one) Other: 4 Nursing Home 5 Passidence 6 Other	(Canadita)
Division of Vital	ding Pt n. After th tuneral	H	1 Yes 2 2 No 10 1	AND NOTIFIED TO THE STUDENCE OF COLLECT	
Divis	af or Attanding Is atter death. It Diractor: After	Sertification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	treet, factory, office 28f. Location (Street and Number City or Town, State)	or Rural Route Number,
	To tha Hospital or Attanu within 24 hours after deatl To tha Funeral Diractor: completely tilled in by the	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dead of the companies of examination and/or and manner stated.	th occurred at the time, date and place, and due to the cause(s) and mann nvestigation, in my opinion, death occurred at the time, date and place, an	ner as stated. Indicate to the cause(s)
	To the vithin 2 To the complet	Ž	29b. Signature and title of certifier		(Month, Day, Year)
	17		30. Name and address o per who completed cause of death (Item 23a) (Type	H58419 AUGUST 3,	TOO?
	12		RODNEY DONAMM, D.O. 1881 TELEGRAPA	ROAD, RISING SW, MD 21911	
	Sta Regist		31. Date filed (Month, Day, Year) AUG 5. 2005	,	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Fecility Name (If not institution, give street 4b. City, Town, or Location of Death County of Death Examiner ESINDOL HESDA ON Bε IGOMER If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min Days Hours NEW YORK Director the Maryland 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits or Items 23a or 28a-f ehow event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director WASHINGTON D.C. NONE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 2 U.S.A. 4200 CATHEDRAL AVENUE, N.W., APT. 206 20016 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. A.I.D. EDUCATION OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GOTTLIEB HENRIETTA ROTHENBERG traumatic ပ ISTDORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20016 4200 CATHEDRAL AVE., NW, APT. 206, WASHINGTON, DC SAUL SHAMPAIN/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 08/02/2005 ROCKVILLE, MARYLAND PARKLAWN MEM. PARK * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 In 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death YEAR Immediate Cause (Final disease or condition resulting in death) 1 **Physician** END STAGE KIDNEY DISEASE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Be Completed by Physician/Medical as the IF FEMALE esn esn 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ed bluods DEMENTIA 2**X** No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 2**X** No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 📉 No Medical Certification; To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After XNatural 5 Pending investigation death. 1 Tyes 2 No hours after death. 2 Accident the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. ş 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur, and title of certifie 10 MD32456 JV4 29 Kristin E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas, M.D. 31. Date filed (Month, Day, Year) State AUG 04 Registrar

				ype or Print in B State of Maryland				•		_	e.
		•	1 - State Registrar	•		tificate of			Reg. No	9 0 0	
			Decedent's Name (First, Middle, Last)					2. Date of Month	_	<u>z u u</u>	3. Tme of Death
	Physicia /Medic		Frank A.	Sim				July	31, 2	2005	10:10 P.M
	Examin		4a. Facility Name (If not institution, give s			4b. City, Town,	or Location o	of Death		. County of	
			Suburban Ho			Bethe		0414-		lontgo	
	uneral irector		5. Social Security Number 208-44-5825 Usual Residence of Decedent	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Yea Months Day			Birth Day, Year 20,	1920 C	Birthplace (State or Foreign Country) zechoslovakia
Maryland	-f show fied at	tor	10a. State 10b. County Maryland Montgome:		y, Town or Loc kville	ation					10d. Inside City Limits
the	r 28a	rec	10e. Street and Number	2) 1200		10f. Zip Code			10g. C	itizen of Wha	at Country?
h with	23a o st be	al D	6121 Montrose Road			2085	2		I	J. S.	Α.
U KIKIO-UUSO illed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Indicatorant: If them Zr is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, Ita Medical Evant mermust be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 		Vas Decedent of Yes, specify Cu Yes 2X N		gin? (Specify Yes or i, Puerto Rican, etc.)	No-		American Indian, White, etc. White
3 10	al E		15. Decedent's Educ	cation	16a. Deced	ent's Usual Occ	upation		16b. F	Kind of Busin	ness/Industry
4 Within 72	r than "ns the Medic	Completed	(Specify only highest grade	College (1-4or 5+) 5+	life. E	kind of work don 00 NOT use reti emical	red)			Coa1	
2	othe vent,	Be C	17. Father's Name (First, Middle, Last)					r's Name (First, Mide		n Sumame)	
vid b	Ment arkad atic e	Lo Lo	Rudolf Sim						rger		
2 sho	is m raum		19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Stre	et and Numbe her Co:	er or Rural Route Nur urt. Gaith	nber, City nersb	or Town, Sta urg. M	ate, Zip Code) Saryland 20879
and and	Health		Susan S. Tatterson 20a. Method of Disposition			ition (Name of	DCI GG	Date			ty or Town, State
iges i	The state		1 ☐ Burial 2 🖺 Cremation 3 ☐ R	emoval from State	emetery, crem	atory or other p					ırch, Virginia
Dallimor Dermit. Pages	niture niture		' 4 ☐ Donation 5 ☐ Other (Specify)21. Signature of Funeral Service License			Cremato		/3/2005			
pe m	tmpo any i		March CV	Tattle much	Da	nzansky	-Goldb	er Memori Pike, Rock	ial C	hapels	s,Inc. vland 20852
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused wo death	n. Do not ente	or the mode of d	ying, such as	cardiac or respirator	arrest,	c, mai	Approximate
Die	unining		Immediate Cause (Final								Interval Between Onset and Death
	ysician Jedical		disease or condition resulting in death)	Due to (or as a consequ	test	inal	nem	orchag		-	3 0445
Ex	aminer			Duode	101	Ulc	21				unknom
	-	ner	Sequentially list conditions, y, leading to immediate cause. Enter Underlying	Due to or as a cons∗,i	иепсе об:		•				
J, executed	n and ial-transii	Examiner	Cause (Disease or injury that initiated events								
	urial-	_	resulting in death) Last	Due to (or as a consequ	uence of):						
OO/O	physic the b	edical	d	l							
-	ding p	/Me	IF FEMALE:	3c. If yes, outcome of pregna	incv					and Date	.f. delia.e
death	been signed by the attending physician should be detached for use as the burial	Physician/Mo	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	Ideath 3□	Ectopic pregnar Other (specify)			-	23d. Date o	,
ecords, F.O.	n signed b uld be deta	ρ	Part II. Dther significant conditions con	tributing to death but not res	ulting in the ur	derlying cause	given in Part I			V	ute to the cause of death? Probably 4 DUnknown
law re	s bee	Completed						24a. W	tas an utopsy	24b. We	re autopsy findings available or to completion of cause of
L 8	ate has page 2	Eo						pe 1 □ Ye	nformed?	dea 0 1	th? Yes 2 No
VITAI ician: T	is certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place	of Death (Check on			
OT VITA Phyaician:	S D	2	1 ☐ Yes 25 No		ER/Outpatien	3 DOA	1012 122	irsing Home 5 R			(Specify)
_ 5	leath. tor; After this the funeral di	atlon;	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In W M 1	juryat /ork? □Yes 2□	28d. Descrit	oe how inju	ury occurred	
DIVISION al or Attending	s after de	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, offic	8		n (Street a Town, Stat		or Rural Route Number,
ne Hospit	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical (sician: To the best of my kno ner: On the basis of examina and manner stated.							
To th	thi mg th	Ň	29b. Signature and title of certifier				nse number				Month, Day, Year)
	3 7 3				1		1116	1	Λ		
_			lu		140	():	5 663		nua	157	12005
2			30. Name and address of person who co	empleted cause of death (Item	n 23a) (Type,	Print)	5 663		NO A)vst	1 2005
2	Sta		A	mpleted cause of death (Item Hence the second seco	n 23a) (Type,	Print) :	Nedi:	col Center	- Driv	e, k	1, 2005 octville, MD

Registrar DHMH 17 Rev 1/2001

Funeral Director or 28a-f show

Division of Vital Records, P.O. Box 68760. this

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST 2 Year **Physician** Rocco John Stellabotte 2005 6:42am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CIVISTA MEDICAL CENTER LA PLATA CHARLES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1∭M 2□F Months 82 579-18-2639 1922 Washington DC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumetic avant, the Mudical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MDCharles Newburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12390 Potomac itams 23a View Drive 20664 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Amed Forces?

1 M Yes 2 In No
1 Of Xes, Give 0 4 5 1 Never Married 2 Married 5 1 ☐ Yes 2 X No Specify: White Specify: 3 ₩ Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumetic avent, the Wades once. Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rocco John Stellabotte Maria Agristi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann M. Kennedy/niece 11175 Lord Baltimore Dr. Issue, MD 20645 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 8-10-05 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4 □Donation 5 X Other to the order to Brentwood, MD Arehart-Echols Funeral Home, P.A. P.O. Box 567 La Plata, MD 20646 M00817 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIO RESPIRATORY ARREST /Medical Examiner TRANSIENT EMIC ATTACK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attanding Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit ELERIUM Due to (or as a consequence of): ASBESTOS/ IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 EMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 PNo Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Diractor: After this d in by the funeral d 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral I 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and tive of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-57708 August 3, 2005 o completed cause of death (Item 23a) (Type, Print)
MD 7-C POST OFFICE ROAD WALDORF MARYLAND 20602 30. Name and address of person who ABBAS A. OMAIS 31. Date filed (Month, Day, Year) AUG 0 5 2005 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 5, 2005 Year **Physician** 10:30 A M Thelma Mae Slane /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Allegany Frostburg Frostburg Village Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 6 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 K F Months Days Hours 6,1916 Pennsylvania Yrs 172-18-1483 88 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "neturel", or Items 23a or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "neturel", or Items 23a or 28e-f show traumatic event, the Madical Examiner rists by molified at 1 ☐ Yes 2 😿 No Completed by Funeral Director Grantsville Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21536 11995 National Pike 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bessie Wiley 2 Calvin Herring 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2709 38th Ave. S.W., Seattle, WA 98126 Deborah Kajikawa/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Grantsville Cemetery August 10,2005 Grantsville, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.O. Box 275, Grantsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARCIONDMA Immediate Cause (Final Lun6 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed OBSTRUCTIVE LUNG HRONIL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Certification: 5 Pending 1 Natural 2 Accident after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated To the within 2 29d, Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier 12690 August 05, 2000 Hycen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.L. Sandhir, 48 Tarn Terrace, Frostburg, Maryland

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

32. Registrar's Signature

2005

	-	For State of M	aryland / Depa <i>Cei</i>	artment of Health and Martificate of Death	ntal Hygiene Reg. No	2005	27120
		Decedent's Name (First, Middle, Last)			2. Date of Death	Vear	3. Time of Death
Physici		Raymond Elmer Schrock			August 7	, 20 0 5	11:30PM
/Medic Examin		4a. Facility Name (If not institution, give street and number,)	4b. City, Town, or Location of Death	40	. County of Death	
		155 Locker Lane		Grantsville		arrett	
Funeral Director		5. Social Security Number 220-30-7874 6. Sex 1. Tax M 2 F	ge (In yrs. last birthday) 78 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year, July 10,	1927 Mar	ece (State or Foreign ryland
pu ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		1/	Od. Inside City Limits
aryla shov	٦						1 ☐ Yes 2 X No
788-1	ect	MD Garrett 10e. Street and Number	Gran	tsville 10f. Zip Code	10g. Ci	itizen of What Coun	try?
with a or	급	155 Locker Lane		21536	US	Δ	
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23s or 28e-f show event, the Madical Examinal must be notified at	Funeral Director	11 Marital Status 12. Was Deceden	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerti		14. Race - America	
or iter		1 Never Married 2 Married 1 Yes 2	No	it Yes, specify Cuban, Mexican, Puero 1 □ Yes 2 X No <i>Specify:</i>	o Rican, etc.)	Black, White, e	etc.
hours after tural', or ite	by	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:		TEL 163 ZEE 110 Specify.		Whi	
72 h	Completed	 Decedent's Education (Specify only highest grade completed) 	(Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b. k	Kind of Business/Inc	lustry
within lene. then	dm	Elementary/Secondary (0-12) College (1-4or	5+1	y Farming	D	airy	
filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide		
uld be i Mental I rked o	<u>m</u>	Elmer Schrock		Sadie	Hershberg	er	
s 1 and 2 should be f Health and Menta Item 27 is marked other treumatic ev	2	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zip	
and 2 : ealth ar n 27 is		Wayne Schrock/Son	149	Locker Lane, P	.O. Box 1	80,Grant	sville
s 1 ar if Hea item 3		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)	Date 20c. L	ocation - City or To	wn, State
	١.	1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Cherry C	Glade Cem. Aug.	10,2005	Acciden	t, MD
permit. Pege Department of Important: If any injury or 20028.		21. Signature of Funeral Service Licensee	22	.O. Box 275, G	wman Fune	ral Home	es, P.A. 21536
		23a. Part : Enfer the disease, or complications that cause shock, of heart failure. List only one cause on each	ed the death. Do not en				Approximate Interval Between
Physician /Medical Examiner whysician and physician and the pringletransit than the pringletransit th	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of): s a consequence of): is a consequence of):	s Disease		0	
The law requires that the death certificate be executed as been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical		2 Fetal death 3 (at time of death 5 (□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	Day Year
v requires tha been signed should be det	Ď	Part II. Other significant conditions contributing to death	but not resulting in the L	inderlying cause given in Part I.		use contribute to the	ne cause of death? pably 4 DUnknown
	Completed				24a. Was an autopsy performed?	prior to con death?	psy findings available mpletion of cause of 2 No
ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	_	Other	ath (Check only one)	. 504 /0 /	
Attending Physician: r death. ector: After this certifics by the funeral director.	on: To	27. Manner of Death 1 XNatural 5 Pending 28a. Date of Ir (Month, L	tient 2 ER/Outpatie njury 28b. Time o Injury	of 28c. Injury at Work?	lome 5 X Residence 28d. Describe how inj		y)
e a te c	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of building,	injury - At home, farm, si etc. <i>(Specify)</i>		28f. Location (Street a City or Town, Sta		ul Route Number,
e Hospitel 24 hours a e Funerel I letely filled	edical C	29a. Certifier (Check only one) Certifying Physician: To the beside the property of the prope	of examination and/or in	th occurred at the time, date and place nvestigation, in my opinion, death occu	e, and due to the cause(urred at the time, date a	s) and manner as s nd place, and due to	tated. the cause(s)
To the within 2 To the complet	₹ E	29b. Signature and title of certifier		29c. Licanse number	29d. D	ate signed (Month,	Dey, Year)
F > F 0		Kar Bash	1	D00342	3/ Au	g. 9, 20	005
m		30. Name and address of person who completed cause of	f death (Item 23a) (Type	, Print)			
O		Dr. Robin Bissell,	M.D., 123	Miller Street	, Grantsv	ille, MI	21536
St	tate	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature				
Regis	trar	AUG 1 1 2005	marine of the	Brank.			

			1 - For State State Registrar		epartment of Health and Certificate of Death		giena 005	27121
			Decedent's Name (First, Middle, Last)			2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Mildred Mattie Sier			August	11, 2005	3:05 A ^M
	Examir		4a. Facility Name (If not institution, give street and i	number)	4b. City, Town, or Location of Dea	ath	4c. County of De	ath
			Citizens Nursing Home 5. Social Security Number 6. Sex	7 A-a //a cosa /a as birth	Frederick (av) If Under 1 Year If Under 24 Hr	2 1 2 2 4 4 2 4 2 4 2 4 2 4 2 4 2 4 2 4	Frederic	
	Funeral Director		220-26-5480	7. Age (In yrs. last birtho	Months Days Hours Mir	. (Month, Day	7, Year) 9. B 7, 1913 Ma	irthplace (State or Foreign Country)
D			Usual Residence of Decedent	71		Sept 2	7, 1913 Ma	ryiand
arylan	show	Ļ	10a. State 10b. County	10c. City, Town o	r Location			10d. Inside City Limits
he M	8a-f.s	Director	Maryland Frederick	Ijamsvi				1 □Yes 2 No
with t	a or 2	Dir	10e. Street and Number		10f. Zip Code		10g. Citizen of What (Country?
death with the Maryland	ns 23	Funeral	4715 Mussetter Road 11. Marital Status 12. Was De	ecedent Ever in U.S.	21754 13. Was Decedent of Hispanic Origin? (JSA 14. Race - Am	perican Indian
after o	or iter		1 Never Married 2 Married 1 7 Ye.	Forces?	If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, Wh	
Z I Z I 3-0036 d within 72 hours af	Exa	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Year or	Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify: W	hite
7 2	"nati	Completed	15. Decedent's Education (Specify only highest grade complete	16a. Do	ecedent's Usual Occupation live kind of work done during most of w fe. DO NOT use retired)	orking	16b. Kind of Busines	s/industry
with N	than than	dwo	Elementary/Secondary (0-12) College unknown	(1-40r 5+)	nstress		clothing r	nanufacture
Filed A	Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)	Scar		ame (First, Middle,		manuracture
yland	dental rked tic ev	To B	Walter Sier		Margare	t Umberge	r	
Mary d 2 shou	and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Modical Examiner must be multified at	-	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street and Number or F			Zip Code)
1 and 2	m 27		Gloria Duke, niece	4715	Mussetter Road,		.e, Marylan	nd 21754
Ore ges 1	Department of Health and Mental Important: If item 27 is marked any injury or other traumatic events.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro	m State 20b. Place of Di cemetery,	sposition (Name of crematory or other place)	Date	20c. Location - City o	r Town, State
SAITIMOF Derrit. Pages	rtmen rtant: njury		'4 □ Donation 5 □ Other (Specify)	Mt. 01i	vet Cemetery 8/1.	5/2005	Frederick,	Maryland
Dan	Depa Impo any		21. lignature Funera Service Licensee	*************	22. Name and Address of Facility K	eeney and	Basford I	Tuneral Home
		-	23a. Part1. Enter the disease, or complications that shock, or(heart failure. List only one cause or	M00999	106 East Church S	treet, Fr	ederick, N	ID 21701 Approximate
200			Immediate Cause (Final			io or roop natory are		interval Between Onset and Death
	ysician Medical			ney Failure o (oras a consequence of):				3 Months
Ex	aminer			h Blood Press				10 Years
D	ii.	Iner	riany, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):				
eecute	and I-trans	Examiner	that initiated events c.	o (or as a consequence of):				
cate be executed	physician and s the burial-transit			o (or as a consequence or).				
ficate	physis the	edical	d					
The law requires that the death certifi	igned by the attending I be detached for use as	Physician/Me		outcome of pregnancy	o∏e		23d. Date of de	livery
deat	ed for	sicla		gnant at time of death	3 Ectopic pregnancy 5 Other (specify)		Month	Day Year
at the	f by the	Phys	9 - Onknown					
ies if	signed be d	by	Part II. Other significant conditions contributing to	death but not resulting in th	e underlying cause given in Part I.		bacco use contribute t	
w requires	been si should	eted	Dementia			1 46	95 2 M NO 3 H	robably 4 Unknown
De law	2 8	Completed				24a. Was a autops perforn	y prior to	utopsy findings available completion of cause of
VILCII I	ficate or, pag	e Co	25. Was page referred to madigat			1 ☐ Yes 2	2 X No 1 ☐ Yes	2 No
/sicia	is certificate ha	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ER/Outpa		ath Check onl on	ence 6 □Other (Spe	7.1
9 A	h. After thi funeral d	n:T	27. Manner of Death 28a. Dat	e of Injury 28b. Time	e of 28c. Injury at		ow injury occurred	scry)
anding	feath. tor: Afi the fur	atlo	2 Accident investigation	nith, Day Year) Injur	M 1 Yes 2 No			
or Atto	irecto	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pla. buil	ce of Injury - At home, farm, ding, etc. (Specify)	street, factory, office	28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
J pital C	urs af eraf D		X			1		
To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical	Check only 2 Medical Examiner: On the	ne best of my knowledge, de basis of examination and/or inner stated.	eath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner a: ate and place, and du	s stated. e to the cause(s)
o the	omple	Me	29b. Signature and title of certifier	inno statos.	29c. License number	25	9d. Date signed (Moni	h, Day, Year)
-	> - 0		· austin P.	Krre	D09689		igust 12,	
			30. Name and address of person who completed ca			At	-puot 12,	2005
			A. Austin Pearre, , Jr.		nth Street, Freder	rick, Mar	yland 2170	1
	Sta Registr		AUG 1 8 2005	Registrar's Signature	wer			

State of Maryland / Department of Health and Mental Hygiene 005 1 - For State Registrar 27122 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9 2023 Daniel Louis Sekowski 2005 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital E1kton Ceci1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 8, 194 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours Min. Yrs. Director 166-32-4530 64 Pennsylvania Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10d. Inside City Limits 10h. County item 27 is marked other then "naturel", or items 23a or 28e-1 show other treumetic event, the Medical Evant for must be notified at 1 ☐ Yes 2 No Directo Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 97 Old Chestnut Road 21921 United States death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 No 1960If Yes, Give 1063 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 1963 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph C. Sekowski Agnes R. Belkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Sekowski/Wife 97 Old Chestnut Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of Cometery, Crematory or other place)

Immaculate 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State August 13, * 4 ☐ Donation 5 ☐ Other (Specify) 2005 Cherry Hill, Maryland Conception Cemetery 22 Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician MYDUARDIAL INFARLTION 30 MIN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signad by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 3510N 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 2□ No 1 ☐ Yes 1 Yes or Attending Physicien; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 ER/Outpatient 1 Yes 2 No ğ Certification: To 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier HYI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellis Elkton, Mo Laura Hugaita Union 31. Date filed (Month, Day, Year) 37 Registrar's Signature State AUG 1 8 2005 Registrar

O5-O5123 DANA TICE WHM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	1aryland		artmen			nd Me		-	2000	07100
	Physici	an	Registrar 1. Decedent's Name (First, Middle, La				moat	J 01 L			2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin	al	Dana LaMo 4a. Facility Name (If not institution, gi		r)		4b. City,	Town, or	Location of		JULY 2		2005 County of Death	9:39 P M
	Funcial		PRINCE GEORGES H. 5. Social Security Number 6.		ENTER	t birthday)	CH If Under	EVER	LY If Under 2	4 Hrs. g	B. Date of Bird		RINCE GEO	
1	Funeral Director			1 ⊠ M 2□F	49	Yrs.	Months	Days	Hours	Min.	(Month, Da uly 15	y, Year)		lace (State or Foreign try)
	Maryland f show	or	10a. State 10b. County	George's	10c. City, 1	fown or Lo		oito1	Heig	hts			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the I a or 28a- be notifi	Director	10e. Street and Number 726 Opus				10f. Zip		207			10g. Citi:	zen of What Coun	try?
(0	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show or other treumatic event, the Madical Examinar must be notified at	by Funerai	11. Marital Status 1 ☑ Never Married 2 ☑ Married	12. Was Deceder Armed Forces	5?	13.	Was Deced f Yes, spec	dent of His cify Cubar		-	ify Yes or No can, etc.))+	14. Race - Americ Black, White,	an Indian, etc.
Maryland 21215-0036	2 hours a aturel', or	ted by	3 Widowed 4 Divorced	1 Tes 2 Notes	:	16a. Deced	1 ☐ Yes	al Occupa	Specify:				эресну.	rican erican
1215	within 73 iene. than "n	Completed	(Specify only highest gi	rade completed) Coflege (1-4o		(Give	kind of wo DO NOT us	rk done d se retired)	uring most o					,
nd 2	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Las	t)	1				ploye 18. Mother		First, Middle,	Nor Maiden		
ryla	should to Ment	၉	Rober 19a. Informant's Name/Relationship	t Lee Tice		19h Mailir	a Address	/Street a	nd Number	or Rural			ne Willi Town, State, Zip	
	and 2 s alth an 27 is er treu		Clementine W. Tie								l Heig	_		
altimore,	Pages 1 and of He ark of h		20a. Method of Disposition 1 Burial 2 Cremation 3 (4 Donation 5 Other (Spec		e cem	etery, crer	sition (Name	ther place	ark	Da			cation - City or To	
Balti	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signatur of Funeral Service Lice	• •	T M	22	. Name an	nd Address	s of Facility	Ste	wart F	uner	andover. al Home ., DC 200	
ki.	Pnysician _/Medical		23a. Part1. Ever the disease, or conshock, or learn failure. List only Immediate Called (Final disease or constitution resulting in death)	one cause on each	ed the death. line.	2NS					respiratory a		М	Approximate Interval Between Onset and Death
	Examiner	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — uue to (or a	เริล ริบกรีฮบุนฮก	ica uf).								
8760,	the burial-transit	dical Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequer	nce of):								
P.O. Box 68	The law requires that the death certifics to has been signed by the attending phage 2 should be detached for use as it	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnanc 2 Fetal de at time of deat	ath 3	Ectopic pr Other (sp					2	3d. Date of delive Month	ry Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death	but not resulting	ng in the ur	nderlying c	ause give	n in Part I.			obacco u: Yes 2	se contribute to th	e cause of death? ably 4 Zunknown
Division of Vital Records,		Completed		I.S.								an osy rmed? 2 \square No	prior to con death?	osy findings available inpletion of cause of
₹	nyeician: ns certifica I director, j	o Be	25. Was case referred to medical examiner? 1X Yes 2 No	Hospitaf: 1 ☐ Inpa	tient 21 FB	VOutpatien	t 3 DC	Othe	_		Check only o		☐Other (Specify	d
o uo	Attending Physician: or death. sctor: After this certific by the funeral director.	tion; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigated	28a. Date of fn (Month, D		Bb. Time of Injury		8c. Injury Work		28	d. Describe f			,
Divisi	- 9	Certification;	3 Suicide 6 Could not 4 Homicide determined	28e. Place of I	njury - At home atc. <i>(Specify)</i>	e, farm, str	eet, factory				f. Location (S City or Tox		d Number or Rural	Route Number,
	To the Hospitel or within 24 hours aft or the Funerel Di completely filled in	edical	29a. Certifier (Check only one) 1 Certifying P	hysician: To the bes miner: On the basis and manner:	of examination	dge, death and/or inv	occurred vestigation,	at the time, in my op	e, date and inion, death	place, an occurred	d due to the at the time,	cause(s) date and	and manner as sta place, and due to	ated. the cause(s)
)	with Tot com	M	29b. Signature and title of certifier				290	O C					30, 200	
2	(3)		30. Name and address of person who	completed cause of	death (ftem 23	3а) (Туре,	,	PENN	STREE	ET, B	ALTIMO	RE,	MARYLAND	, 21201
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 5 200		trar's Signatur	ha	Ri				-			

Registrar DHMH 17 Rev 1/2001

State

lower & Sparke

SURESH VERGHESE, MD, 11701 LIVINGSTON RD., #101M FT. WASHINGTON, MD 20744-5126

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

31. Date filed (Month, Day, Year)

AUG 0 5

32. Recentrar's Signature

		For State Registrer	State of Maryland / Depa Cer	artment of Health and rtificate of Death	Mental Hy	giene 005	27125
Physician		1. Decedent's Name (First, Middle, Last) Jane Issac Thompso	ın		2. Date of D Month Aug.		3. Time of Death 1:45 a
/Medical Examiner		4a. Facility Name (If not institution, give st		4b. City, Town, or Location of Dec		4c. County of Dea	
Funeral Director		Laurelwood Center 5. Social Security Number 217 20 5568	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi). (Month, D	av Year	nthplace (State or Foreig ountry) Yland
aryland		10a. State 10b. County	10c. City, Town or Lo		×		10d. Inside City Limits
or 28e-f		Maryland Cecil 10e. Street and Number	Rising S	10f. Zip Code		10g. Citizen of What C	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Itema 23a or 28e-f show appropriate to other treumatic svent. The Medical Examinar must be notified at ance. To Be Completed by Funeral Director.	Laureral	1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U.S. Armed Forces?	21911 Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pue 1 □ Yes 2₺ No Specify:	Specify Yes or Norto Rican, etc.)		erican Indian, ite, etc.
ed within 72 hours all ygiene. It, the Medical Examit.	pleten by	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates:	dent's Usual Occupation kind of work done during most of w	orking	Specify: \	White
be filed with tal Hygiene d other the svent, the Be Com		17. Father's Name (First, Middle, Last)	Aeeem	bly Line	ame (First, Middle	Electric e, Maiden Surname)	Motors
to 2 should be file thand Mental Hy to 1s marked oth treumatic svent To Be	0	Martin Isaac 19a. Informant's Name/Relationship (Typo	a Print) * 10h Mailin	Jane	Riddle	nor City of Town State	Tin Coda)
is 1 and 2 s of Health an item 27 is other treu	-	Martin A. Thompson	371 EI	benezer Church R	oad Ris	ing Sun, Ma	ryland
permit. Pages 1 and Department of He Importent: If item any Injury or othe ODEs.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Funeral Service Liberises	Ebenezer	Cemetery Rugs	127 127	Rising Sun	
88 5 8 8	-	23a. Part1. Enter the disease or complice shock, or heart failure. List only one		er the mode of dving such as cardi	me Nort	h East, Mar	yland 2190
Physician /Medical Examiner		shock, or heart failure. List-only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	THRILE			Interval Between Onset and Death
ficate be executed physicien and is the burial-transit	7	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): PAF Due to (or as a consequence of):	() Not we			
Physicien: The law requires that the death certifical rithis certificate has been signed by the attending phyral director, page 2 should be detached for use as the To Be Completed by Physician/MedI: To Be Completed by Physician/MedI		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
w requires that been signed to should be determined by PI	2	Part II. Other significant conditions control Extensive Facial		nderlying cause given in Part I.		tobacco use contribute to	
ticlen: The law requires to certificate has been signe rector, page 2 should be completed by					24a. Was auto perfo 1 Yes	psy prior to death?	utopsy findings available completion of cause of
After fune	2	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	spital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	0. 1		one) idence 6 Other (Spe	icify)
To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After completely filled in by the funera Medical Certification:		3 Suicide 6 Could fot be determined	28e. Place of Injury - At home, farm, streen building, etc. (Specify)	eet, factory, office	28f. Location (City or To	(Street and Number or Ri wn, State)	ural Route Number,
o the Hospit thin 24 hours the Funere ompletely fille		29a. Certifier (Check only one) 15 Certifying hysic 2 Hedical Exemine	cian: To the best of my knowledge, death ir: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place estigation, in my opinion, death occ	e, and due to the curred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
To the within To the comple		29b. Signature and West to Viriler		29c. License number D54673		29d. Date signed (Mont	
3		30. Name and or sperson who com	pleted cause of death (Item 23a) (Type, F		wc457LE	DE 1572	O
State Registrar	_	31. Date filed (Month, Day, Year) AUG 5 2005	32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Judy Gail Tawney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13921 Craddock Road Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□ F Days Hours Min. 215-74-3629 48 Director 3,1956 Dec. MD Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28e-f show the Medical Exampler must be notified at 1 Yes 2 No Allegany Cumberland Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 13921 Craddock Road 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hostess Restaurant permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Importent: if Item 27 is marked oths any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy W. Oakes Lorraine B. (Hudson) Oakes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. White - fiance 13921 Craddock Road; Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns. 8/16/2005 Timonium, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityScarpelli Funeral Home, P.A. M Cumberland, MD 21502 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease shoo, or heart failure. List only one cause on each lin Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Melanoma **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Cluses or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown for Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate has autopsy 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H. Chatam 058853 8/12/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 131 PENNSYLVANIA AVE, CUMBERLAND, MD 21502 HABIB CHOTANI 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 8 2005

DHMH 17 Rev 1/2001

Registrar

/I <i>F</i>	AN VAUG	HN:	For State Registrar	State of	of Maryland /	Depa <i>Cer</i>	rtment of H	ealth a Death	nd Menta	l Hygien	20	05	271	27
145	A	*	Decedent's Name (First, Middle							of Death	ay	_ Year	3. Time o	
	Physicia /Medic	4.0			aughn						² 200		091	2 A M
10 m	Examin	er •	4a. Facility Name (If not institution PRINCE GEORGES	-	CENTER		4b. City, Town, or CHEVELY						EORGES	
"水. 風·	Funeral Director		5. Social Security Number 577-80-2850	6. Sex 1 ☐ M 2 X F	7. Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mo	of Birth nth, Day, Yea 29-19	56	9. Birthp Cour Ohic	place (State ntry)	or Foreign
	and w		Usual Residence of Decedent 10a, State 10b. County		10c. City, To	wn or Lo	cation					1	10d. Inside 0	City Limits
:	Maryl -f eho	ğ	MD	PG		Upp	er Marl	boro					1 X Yes	2 □ No
3	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: If tien 27 is marked other than "natural; or iteme 23a or 28a-f ehow any injury or other traumatic event, the Modical Exactic at most be ricitized at Apple. ADDGE.	Funeral Director	10e. Street and Number 152 Joyceto:	n Terr.			10f. Zip Code 2	0774		10g. 0		What Coul	ntry?	
	r teme 2	Funer	11. Marital Status X2Never Married 2 Marr	Armed F ied 1 ☐ Yes	2 X No		Vas Decedent of Hi Yes, specify Cuba		in? (Specify Ye Puerto Rican, i	s or No- etc.)	Bla	ick, White,		
3	iral', o	þ	3 Widowed 4 Divorced	If Yes, G Year or I	ive Dates:		∏ Yes 2012 No	Specity:			Speci		31ack	
<u>ה</u>	"natu	lete	15. Deceden (Specify only highes	t's Education It grade completed,) 16	a. Deced (Give life. I	lent's Usual Occupa kind of work done o OO NOT use retired	ition luring most	of working	16b.	Kind of E	Business/In	ndustry	
717	y within	Completed	Elementary/Secondary (0-12)	Co p ege ((1-4or 5+) R e			_	apist	P	riva	ite		
מנומי	oe filed al Hyg d othe event,		17. Father's Name (First, Middle,	-					's Name (First,			me)		
<u>8</u>	d Menidi d Menidi narke	To Be	James H. Va	aughn	10	h Mailin	ig Address (Street a	Wanda			ark	State Zir	Code)	
, Ma	and 2 sl salth an n 27 is r er traur		Wanda Vaughn		: 1	52	Joyceto	n Tei	rr., U	pperma	ar1b	oro,	MD	20774
altimore	Pages 1. ent of He nt: If iten ry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State		sition (Name of natory or other place 11 Cem.		Date - 10 - 20				own, State	
Dall	permit. Departm Importa any inju		21. Signature of Fune al Service	Licensee de	Lett		Name and Addres		•					0002
×			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death. Do	not ent	er the mode of dying	g, such as o	cardiac or respir	atory arrest,			Approxima Interval Be	tween
)	Physician		Immediate Cause (Final disease or condition	a			embolism	N					Onset and	Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequence		thromb	MIK						:
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consequence		Truction	V-40			-			
	be executed ician and burial-transit	Examiner	Cause. Enter Orlderlying Cause (Disease or injury that initiated events resulting in death) Last	С										
8/00,	be exe sician a burial-		resulting in death) Last	Due to	(or as a consequence	e of):								
20	certificate Iding phys	edical		d										
ROX		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live 4 ☐ Preg	utcome of pregnancy birth 2 Petal dea mant at time of death		Ectopic pregnancy Other (specify)					ate of deliv	rery Day	Year
	that the o	hysi	9 X Unknown	9□ Unki										
ras,	w requires that the death been signed by the atte should be detached for	by	Part II. Other significant condition	ons contributing to	death but not resulting	in the u	nderlying cause give	en in Part I.		e. Did tobacc		3 ☐ Prol		death? JUnknown
Records,	e las has	Completed							24	a. Was an autopsy performed:	!	geath?	opsy finding ompletion of	s available cause of
-	I lcian : The certificate harrector, page	e Co	25. Was case referred to medica	1		-		26 Place	of Death (Chec		No	Yes	2□ No	
>	Physician: r this certifica ral director, p	To B	examiner? NOXYes 2 □ No	Hospital:	Inpatient 2X ERV	Dutpatien	it 3 DOA Oth	ar	rsing Home 5		6 □Ot	her (Speci	(y)	
	ifte ou		27. Manner of Death 1 Natural 5 ☐ Pendir	28a. Date (Mo.	of Injury 28b nth, Day Year)	. Time of Injury	Worl			scribe how in	jury occu	rred		
DIVISION	Attending r death. ector: After by the funer	ficati	2 Accident investi	not be 28e. Plac	e of Injury - At home,	farm, str		Yes 2□N	28f. Loc	cation (Street		ber or Run	al Route Nu	m <i>ber</i> ,
2	tal or / rs after al Dire ed in b	Certification:	4 Homicide	buile	ding, etc. (Specify)				Cit	y or Town, Sta	ate)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai		Examiner: On the	ne best of my knowled basis of examination a nner stated.									(s)
	To t To t	Σ	29b. Signature and title of certifie				29c. License	.M.E			_	ed (Month, 3, 20	. <i>Dey</i> , Year) 005	
0	(10)		30. Name and address of person	who completed car	use of death (Item 23a	(Type	Print)					٠, ۷		
4	(10)		Pamela B. Sir	othali, mo	111 PE	ŃŃ S'	TRÉET, BAL	TIMOR	E,MARYL	AND 212	201			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 15 2	005 Be	Registrar's Signature	Good	le							

			1 - For State Registrar	State of M	faryland /		artment rtificate			and M	,	giene Reg. Nør	00			
			Decedent's Name (First, Middle, Last)							2. Date of De	ath	UU)	3. Time of geath	_
	Physici /Medio		ALICE JEANNE	WHYTE							Month Aug.	02.	2005	ear	9:17 PM	
	Examir		4a. Facility Name (If not institution, give	street and numbe	r)		4b. City, To	own, or	Location of	f Dealh			County of			
			Hartley Hall Nursi	ng Home					e City			Wo	rcest	cer		
	Funeral		5. Social Security Number 6. Se	7. A	ige (In yrs. last		If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9	Birthp	ace (State or Foreign	
	Director		218-52-8982	JM 201	59	Yrs.					Oct. 6,		5 Wa		ngton, D.(3
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation							11	Od. Inside City Limits	_
	Aaryli F sho	5	MD Worcester	•	Stock										1 ☐ Yes 2 No	
	28a-	Director	10e. Street and Number		BLOCI	KUOII	10f. Zip C	ode				10a Citi	zen of Wha	I Coun	to/2	_
	with la or	Ō	6008 George Islan	od Landir	or Pood		2180					· · · · ·	USA	, 000.	,	
	leath	Funeral	11. Marital Status	12. Was Deceder		13.			spanic Orio	gin? (Spe	cify Yes or No)- ·	14. Race -	Americ	an Indian.	_
	fter d	Fun	1 X Never Married 2 Married	Armed Forces	?		f Yes, specify	/ Cubar	n, Mexican	, Puerto I	Rican, etc.)		Black,			
036	or, je	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 Yes 2	No	Specify:				Specify:	whi	te	
21215-0036	be illed within 72 hours efter death with the Maryland tal Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, the Madical Examinar must be notilled at	Completed	15. Decedent's Edu	cation	1	6a. Dece	dent's Usual	Occupa	tion	. m.f mlei:		16b. Kir	nd of Busin	ess/Inc	lustry	_
2		pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4o	r 5+)	lite.	kind of work DO NOT use	retired)	uring most	OF WORK!	ng					
7	gien gien er th	NO.	12	3. (Resta	urant	Mar	nager			Food	Serv	/ice	<u> </u>	
b	al Hygid I other vant,	Be (17. Father's Name (First, Middle, Last)						18. Mother	r's Name	(First, Middle,	Maiden	Sumame)			
<u>a</u>	Mental Mental arked o	70	Cromer Whyte						Aile	en A	rdis					
Maryland	s i end 2 should be filed withir F Health and Mental Hygiene. Item 27 is marked other than other treumatic evant, the M	10	19a. Informant's Name/Relationship (T)	rpe, Print)	1	19b. Maili	ng Address (S	Street a	nd Numbe	r or Rura	l Route Numbe	er, City o	Town, Sta	te, Zip	Code)	
	면 들었 분		Anthony A. Trader	(Adminis	strator) 123	Ames	Pla	aza, l	Poco	moke Ci	ty,	MD 21	851		
ore.	ges 1 er t of Hea If Item or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	tamaval from Stat	come	e of Dispo	sition (Name natory or oth	of er place)	D	ate	20c. Lo	cation - Cit	y or To	wn, State	
Ĕ	Page nent o ant: If ury or		'4 Donation 5 Other (Specify)	emoval from Stat		n's C	bretery		8	/6/2	005	Oak	Hall	. Vi	rginia	
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			23a. Part1. Enter the disease, or complishook, or heart failure. List only o	ications that cause	ed the death. E										Approximate Interval Between	
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9	ntifica ng ph as th	1 00 1	IF FCMAN C													
Box	eath certific attending p	an/N	230. Was decedent pregnant	3c. If yes, outcom	e of pregnancy 2 DFetal de		Ectopic preg	nancy				2	3d. Date o		*	
	dea death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death		Other (spec						Month		Day Year	
P.0	at the de by the	Physician/M	9 Z Unknown													H
	res tha igned be det	by	Part II. Other significant conditions con	ntributing to death	but not resultin	ng in the u	nderlying cau	se give	n in Part I.						e cause of death?	
Records,	w require been sig	ted									1 🗆 '	Yes 2[24No 3[] Prob	ably 4 DUnknown	
900	law nas be	Completed									24a. Was autop		24b. Wer	e autor	osy findings available	
Ä	n: The la icate ha r, page 2	EO									perfo	rmed? 2 No	dea	th?	2 No	
Vital	sician: certifica rector, p	Bec	25. Was case referred to medical						26. Place	of Death	(Check only o					
†	S .0	10 E	examiner? 1 \sum Yes 2 \sum No	łospital: 1 □ Inpa	lient 2□ER/	/Outpatier	I 3□ DOA	Other	r. 4 Nur	rsing Hor	ne 5 🗆 Resi	dence 6	Other (Specify)	
lof			27. Manner of Death	28a. Date of In (Month, D	jury 281	b. Time of	280	: Injury Work	at ?	2	28d. Describe I	now injury	occurred			
ō	Attending in death. ector: After by the fune	atic	2 Accident investigation		.,,	,,	М		es 2□N	No						
Division	or Attencation date death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I	njury - At home etc. (Specify)	, farm, str	eet, factory, o	office		2	28f. Location (3 City or Tox	Street and	l Number o	r Rura	Route Number,	
O	tel or A rs after al Direced in by	Cer			,,,							,,				
	houner uner uner		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the bes	t of my knowled	dge, deatl	occurred at	The time	e, date and	d place, a	and due to the	cause(s)	and manne	er as sta	ated.	
	To the Hospitel or within 24 hours atte To the Funeral Dirt completely filled in I	ledical	(Check only 2 Medical Exami	and manner	slated.	and/or in				ar occurre						
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•							9	5	44.	12			8-3	2 - (75	
- 1	1 11		30. Name and address of person who co	mpleted cause of	death (Item 23	a) (Type)	Print)			^			1			-
1	1, 7		1604- March		Stig	To	con	wk	ce,	(M	0 2	1187	51			
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 5 20	05 32 legis	trar's Signature	4	con		·							

		1	For State Registrer	State of Man		artment of the		and Ment		iene g. n2 0 0	5 27129	
			Decedent's Name (First, Middle, Last))					ate of Deat		3. Time of Death	
	Physicia /Medic		JAMES E. WINDSOR	<u> </u>					COST	01,200	5 10.304 M	
	Examin		la. Facility Name (If not institution, give			4b. City, Town,	or Location of	of Death		4c. County o		
			Doctor's Communi		1 In yrs. last birthday)	Lanham If Under 1 Year		24 Hrs. 8, D	ate of Birth		e George's 9. Birthplace (State or Foreign Country)	
	Funeral Director			M 2□F	59 Yrs.	Months Days		Min. (A	ch 8,	^{Year)} 1946	Country) Mary Land	
			Usual Residence of Decedent								10d. Inside City Limits	_
	arylan show		10a. State 10b. County		0c. City, Town or Lo						1 Yes 2 No	
	he M	ectc	Maryland Prince G	eorge's	Upper Mar	10f. Zip Code			1	0g. Citizen of W	hat Country?	_
	with with	ā	3905 Bishopmill F	21 000		20772				U.S.A.		
	death	Jera	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of if Yes, specify Cub	Hispanic Ori	igin? (Specify '		14. Race	- American Indian, k, White, etc.	_
ဖွ	or Its	by Funeral Director	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 X No		1 □ Yes 2 🖾 No			., 0.0.,	Specify:		
21215-0036	72 hours after death with the Maryland Insturati, or ttems 23a or 28a-f show dical Examination multibed at	q p	3 Widowed 4 Divorced	Year or Dates:	16a Dece	dent's Usual Occu	nation			16b. Kind of Bus	White siness/Industry	_
15	in 72 i "nat	Completed	15. Decedent's Edi (Specify only highest grad	ie completed)	(Give	kind of work done DO NOT use retire	during mos ad)	t of working		100, 14110 01 04		
212	within giene.	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Roof	ing				Constru	ction	
b	e filed within al Hygiene. I other than '	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (Firs	st, Middle, I	Maiden Sumame	θ)	
Maryland	2 should be and Mental Is marked o	2	Warren Gregory Wi				Sopl	nie Vic	toria	Tayman	24-4- 7:- O-4-1	_
Jar	12 sho		19a. Informant's Name/Relationship (7		Common and						State, Zip Code) 20772	
d)	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene with an articlar Hygiene with an articlar Hygiene with a marked other than "natural", or thems 23a or 28a-f show item 27 is marked other than "natural", or thems 23a or 28a-f show other traumatic event, the Medical Examina must be notified at	1	Joseph Windsor - 20a. Method of Disposition	Brother	20b. Place of Dispo	sition (Name of		lace, U	pper_	Marlboro	O Mary Land City or Town, State	
nor	ages ant of t: If it y or o		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Metropolit	matory or other pla an Cremati		8/3/200	05 A	Alexandr	ia, Virginia	
Baltimore,	permit. Pages 1 Department of I Important: If its any injury or of		21. Signatur of Funeral Service Licen			and the second s		Secretary in the Section of the Sect			ome, P.A.	
ä	Depa Impo any ii		1 Sleet	11/ay		739 Balti				-	MD 20781	
			23a. Part 1. Enter the disease, or composhock, of heart failure. List only	olications that cause the	ne death. Do not en	ter the mode of dy			piratory arr	est,	Approximate Interval Between Onset and Death	
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oʻ	e exection are trial-tr		resulting in death) Last	Due to (or as a	consequence of):							
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Вох	atten d for u	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 4 Pregnant at ti		⊒Ectopic pregnan ⊒ Other (s <i>pecify)</i>	cy			Mor	nth Day Year	
O.	that the de led by the a detached t	hysi	9 Unknown	9□ Unknown						1		
s, P	Se 25 00	by P	Part II. Dther significant conditions of	ontributing to death but	not resulting in the	inderlying cause g	jiven in Part	L.	23e. Did to		ribute to the cause of death? 3 □ Probably 4 □ Unknown	
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Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	t 2 ER/Outpatie	nt 30 DOA)th on	e of Death (C/		ence 6 Othe	Br (Specify)	
of	y Phys ar this eral di	-	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time					ow injury occurr		_
ion	Attending In death. ector: After by the funer	atio	1 Natural 5 Pending investigation		, ear, injury		Yes 2					
Division	or Attencations after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, larm, s (Specify)	treet, factory, offic	е	28f.	Location (S City or Tow	Street and Numbern, State)	er or Rural Route Number,	
	urs aft eral Di		Continue Di	ysician: To the best of	mu knowledne des	th occurred at the	timo data a	and place, and	due to the d	rause(s) and ma	unner as stated	-
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier Certifying Ph (Check only 2 Medical Exar									
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Lice	nse number		- 1	29d. Date signed	d (Month, Day, Year)	
	->-0) Asfr	men!	1 1	D 1/88	606	//		8	115007	
0	(3)		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	, Print)	. 1	4.111	. A	20 72	,	
1	9		SAMUEL ASFAW	1 M.D. 8//	ath (Item 23a) (Type & COOD L	UCK LOA	DL	AUHAM	, 100	0010	/	
	St Regist	ate trar	31. Date liled (Month, Day, Year) AUG 0 5 200	5 Registral	& L	refle						
			700 00 200	- JAMES	7							_

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

		,	For Unpend Item 2 State Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylan 3a&27 per me	Ce	artm <u>e</u> rtifica	ot of He 05 tal te of L	ealth and leath	Mental Hyg		005	2713		
	Physici	an		ANISSA COOK W	ORTHIN	VGTON	Ī		AUGUST	Day	2005	11:45 A ^M		
	/Medic Examin		4a. Facility Name (If not institution, give s UPPER CHESAPEAKE M				r, Town, or I	ocation of Deat		4c. C	County of Death			
	Funeral Director		5. Social Security Number 6. Sex 220-69-6498	7. Age (In yrs. I.	ast birthday) Yrs.	If Und Months		Hours Min.		Year)	9. Birth Cou	place (State or Foreign ntry) aryland		
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Hari		, Town or La	ocation	Bel	Air		10d. Inside City Limits 1 X Yes 2 □ No				
	h with the	Funeral Director	10e. Street and Number 806 Comer Sq	uare		10f. Z	ip Code 21	014	1	10g. Citize	Citizen of What Country? USA			
036	s 1 and 2 should be filed within 72 hours after death with the Maryland fleatint and Mental Hygiene. If Heatint and Mental Hygiene a fleam 21 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Medical Examinal must be notified at	5	11. Marital Status 1 Mever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates:	- 1	Was Dec If Yes, sp		panic Origin? (S , Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: Black			
Maryland 21215-0036	I within 72 ho liene. r then "natur: the Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dece (Give life.		ual Occupat rork done du use retired) 'er Wo:	ion ring most of wo rked	rking	16b. Kind	d of Business/Ir	ndustry		
yland	2 should be filed within and Mental Hygiene Is marked other than sumatic svent, the Ma	To Be C	17. Father's Name (First, Middle, Last) Kenton Harvey Wor					Nadine	_{me (First, Middle,} e Marchel	le J	ohnson			
	t and 2 shows the stand the stand the stand the stand the stand the standard the st		19a. Informant's Name/Relationship (Ty) Nadine M. Johnson	/ mother	806	Come	r Squa	are, Bei	ural Route Numbe la Air, M	ŕ				
Baltimore,	permit. Pages 1 a Department of Hes Importent: If Item sny injury or othe once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State	ame of other place Cen	etery 8			c. Location - City or Town, State Iavre de Grace, MD					
Balti	permit. Pages Department of H Importent: if Ite any injury or of once.		21. Signature of Funeral Service License	98 St.	2:	Lisa 552	and Address SCOT	of Facility Funera	al Home, Havre d	P.A.	ago ME	21070		
	hysician /Medical Examiner	9.	23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Acute myocar Due to (or as a consequ	rditis uence of):		ode of dying	such as cardia	c or respiratory ari	est,		Approximate Interval Between Onset and Death		
68760,	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter underlying Cause (bisease or injury that initiated events resulting in death) Last	Due to (or as a consequ										
.O. Box (that the death certificate ed by the attending phy detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3[⊒Ectopic ⊒ Other (pregnancy specify)			23	8d. Date of deliv Month	ery Day Year		
rds, P.	quires that n signed b uld be deta	þ	Part II. Other significant conditions con	ntnbuting to death but not resu	Ilting in the u	ınderiying	cause giver	in Part I.				the cause of death?		
		e Completed	25. Was case referred to medical					ne Place of Do	24a. Was a autops perfor Yes	sy med? 2□ No	prior to co death?	opsy findings available impletion of cause of		
5		To B	avaminar?	lospital: 1 Inpatient 2	ER/Outpatie	nt 3(X)	Other		Home 5 Resid		□Other (Speci	fv)		
ion oi	nding Phy th. r: After thi e funeral		27. Magner of Death 1 Astural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	- 41	28c. Injury Work		28d. Describe h			,,		
Division	To the Hospital or Attending Physically the Nours after death. To the Funerel Director: After this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		reet, facto	ory, office	-,	28f. Location (S City or Tow		Number or Rur	al Route Number,		
	ts Hospi 24 hour e Funer letely fills	edicai (icium: To the best of my knowner: On the basis of examinat and manner stated.										
)	To the within To the comp	Me	29b. Signature and title of certifier	116		2	9c. License O C	number M E	Z		signed (Month,			
*			30. Name and address of person who co	Impleted cause of death (Item	23a) (Type,		PENN	STREET.	BALTIMOF	RE. M	IARYLANT	o. 21201		
	Sta Regist		31. Date filed (Month; Day, Year) AUG 1 6. 2005	32. Registrar's Signa	ander	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar		artment of H tificate of			giene Reg. No? (300	07100
			Decedent's Name (First, Middle, Last	")				2. Date of De	ath	100	3. Time of Death
	Physici /Medic		Janice Lynn	Winazak				July 31	, 2005	Year	5:10 a _M
}	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o		ath		inty of Death	
			4049 Rural Place 5. Social Security Number 6. Se	7. Age (In yrs.	last hirthday)	Salish		s. 8. Date of Bir	lb.	LCOMIC	
	Funeral Director		261–47–3259	□M 284F 46	Yrs.	Months Days	Hours Mil		y, Year) 1959		place (State or Foreign intry) Cyland
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ty, Town or Lo	cation					10d. Inside City Limits
	Mary 3-f sh	tor	Maryland Wicomi	co S	alisbur	У					1 ☐ Yes 2 No
	ath with the Marylan 23a or 28a-f show	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	ntry?
	s 23a		4049 Rural Place			218			USZ		
396	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, If a Mulical Externit and the Itemitation	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ⚠No If Yes, Give Year or Dates:	1	Nas Decedent of F f Yes, specify Cub 1 ☐ Yes 2 🕱 No	Ispanic Origin? I an, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)		Race - Ameri Black, White, ec <i>ify:</i> W	
9-0	72 hou	ted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	lent's Usual Occup	pation	nokina	16b. Kind o	f Business/Ir	ndustry
21215-0036	within 7 ene. than r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done OO NOT use retire	d)	UKING	T7		
42	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)	2	Sales	•	18. Mother's N	ame (First, Middle,	Veri		
Maryland	ould be f Mental I warked of	o Be	George Grossman					ed Murphy			
lary	2 should land Meni ls marke		19a. Informant's Name/Relationship (7			•		Rural Route Numbe			p Code)
ď	of Health item 27 t		Dale F. Winazak/h			Rural P	lace, Sa	alisbury,		804 on - City or T	Canal State
Baltimore,	8 5 ± 2		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from State	cemetery, cren	natory`or other pla	· Q/	2/05			
ıtin	permit. Pa Departmer Important any injury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			y Cremat Name and Addre	OLY			sbury	, MD sociation
ñ	De	•	David H. Us	moss CFS	P 150	11 Snow H	ill Rd.	. Salisbu	rv. ML	nal Ass 0 21804	sociation 4
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea one cause on each line	th. Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,	SHI DEVES	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Meta	elate	R Bro	ast (ancer	8		2 years
	/Medical Examiner		Todaking in doday	Due to (or as a conse	quence of):						0
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Unidenting Cause (Disease or injury	b. Due to (or as a conse	quence of):						
	ficate be executed physician and is the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c.							
60,	be exician a	al Ey	resulting in death) cast	Due to (or as a conse	quence on:						
68760,	ficate physics the	edlcal		d.							
Вох (death certifi e attending s ed for use as	m/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Tertonia orocana			23d.	Date of deliv	ery
	e death	Physician/M	in the past 12 menths? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of		Ectopic pregnanc Other (specify)	у			Month	Day Year
P.0	that the de ned by the a detached		9 ☐ Unknown Part II. Other significant conditions co	ontributing to death but not re	sulting in the w	nderlying cause giv	ven in Part I.	23e. Did t	obacco use o	contribute to t	the cause of death?
ds,	uires t signe	d by			g	,			res 2□No		
COL	law requires as been sign 2 should be	olete						24a. Was		b. Were auto	opsy findings available
Vital Records,	0 5 0	Completed						autor perfo	rmed?	prior to co death? 1 \(\sum \text{Yes}	ompletion of cause of 2 No
/ita	certificate rector, pag	Be	25. Was case referred to medical examiner?	I de la calcada				eath (Check only o	ne)		
of \	this ald	. To	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 2	ER/Outpatien	100	4 Nursing	Home 5 Thesis			fy)
	ng ftei ftei	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk? Yes 2 □ No	200. 2000/100 1	iow injury oc	Curred	
Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h		eet, factory, office		28f. Location (: City or Tox	Street and Nu	ımber or Run	al Route Number,
Ö	urs after ral Dire							1			
	To the Hospital or within 24 hours after To the Funeral Directorypietely filled in D	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exemone)	ysician: To the best of my kn liner: On the basis of examin and manner stated.	owledge, death ation and/or in	n occurred at the ti vestigation, in my o	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and date and plac	l manner as s ce, and due t	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0		29c. Licens	se number		29d. Date sig	gned (Month,	Day, Year)
•	Z)		Salar Z.	linton, 1	2	000	15671	76	8/1/0	05	
	10		30. Name and address of person who co	completed cause of death (Ite	m 23a) (Type,	Print)	e Drat i	57 (DICE	1,011	אחטוני חא
	Sta		31. Date filed (Month, Day, Year) AUG 0 4 2	completed cause of death (Ite)	lature	1 . W .	INV-L	11. 10	-17136	1/1	11. 71001
	Regist	ar	AUG U 4 Z	UUJ Madage o	17. 1.	malle					

		1	For State Registrar		5	State o	f Mary	yland	-	artmen			and Mer	ntal Hygi	ene g. No 2	n 5	27133	
	نة ا . ا .		. Decedent's Name	e (First, Middle,	Last)								2.	Date of Death Month		Year	3. Time of Death	
Phys /Me	edica	1		Jean W						41 07				uly	26 Caust	2005 by of Death	04:47A M	_
Exar	mine		a. Facility Name (/		•			1		4b. City, Tako		Location of	of Death		v			
Funer	ral		Washington Social Security N	lumber	6. Sex		7. Age (I.	n yrs. la	st birthday)	If Under	1 Year	If Under	24 Hrs. 8. Min.	Date of Birth (Month, Day,		9. Birthp	lace (State or Foreign	-
Direct		L	579–56 – 0.		1 🗆 M	2 5 F		59	Yrs.	Months	Days	Hours	Oc	t. 30,	1945		ington, DC	_
and		_ <u>_</u>	Jsual Residence of 10a. State	10b. County			1(0c. City,	Town or Lo	cation						1	0d. Inside City Limits	_
Mary Ff sho		D M	aryland	Montgo	mery			Сарі	itol H	leight	s						1 ☐ Yes 2 XNo	
d 21215-UU36 filed within 72 hours after death with the Maryland Hyglene. wither then "netural", or Itams 23e or 28e-f show ant, the Macinal Examiner mast be notified at	١,	DIrecto	10e. Street and Nu	mber						10f. Zip	Code			10	g. Citizen of		itry?	
ath wi		<u></u>	1706 Rol	lins Pl						L .	20743		1.0.10	V 1	U.S.	A.	an Indian	_
ter de Itams		Funeral	 Marital Status Never Marr 	ied 2⊑ Marni		Was Dece Armed Fo	orces?	er in U.S	5. 13.	was Deced	ent of He	n, Mexicar	gin? (Specin n, Puerto Ric	y Yes or No- an, etc.)		ack, White,		
Z1Z15-UU36 Id within 72 hours af giene. ar then "netural", or		2	3 Widowed	41		If Yes, Giv Year or D	ve lates:			1 ☐ Yes	2 ₩ No	Specify:			Spec	ify: B1a	ck	
5-C 72 ho 72 ho		Completed	(Spec	15. Decedent					16a. Dece	dent's Usua kind of wo	l Occupa k done d	ition <i>uring</i> mos	t of working		16b. Kind of	Business/In	dustry	
Mithin Methin		d l	Elementary/Seco		Ī	College (1	1-4or 5+))			ont o	of Com	morco	
ICI ZIZ		္မွ	17. Father's Name	(First, Middle, L	ast)				Stend	grapi	ier	18. Mothe	er's Name (F	First, Middle, N	ept. o Maiden Suma		merce	_
a d a b a	1	0	George P	eterbar	k						1	[sabe	11e Mu	ırphy				
Maryland d 2 should be file th and Mental Hy 7 Is marked oth traumatic avent		1	19a. Informant's N					Ш						Route Number,				
C = 14 F		1 1-	Curtis Wi		Husb	and			L/06 H ace of Dispo			Lace	Capito	ol Heig	Oc. Location			-
			t X Burial 2	Cremation		noval from	State	ce	metery, crei	natory`or o	ther place			2005 B				
Baltimore, permit. Pages 1 a Department of Hes Important: If itam any injury or othe	oi	+	' 4 ☐ Donation 21. Signature of Fe			1		ror	22	2. Name ar	d Addres	s of Facili	y Fort	Lincol	n Fu	neral	Home	
Per g	g		lan	- 4.	Hi	ly			34	401 B	Ladeı	ısbur	g Rd.	Brentw	rood, l	MD 207	22	
	£		23a. Part1. Enter	the disease, or	complica only one	tions that o	caused the	e death.	. Do not ent	er the mod	e of dying	g, such as	cardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death	
Priyaicia			Immediate Cause disease or condition	on	a	K	in	d	fu,	un	2						Onset and Douth	
/Medic Examin			resulting in death)			Due to	(or as a c	cons	ence of):									
EN	4	e_	Sequentially list co if any, leading to in	onditions, mmediate	b.	Due to	(or as a c	consequ	ence of):									-
cuted id ansit		Examiner	Cause (Disease or that initiated event	r injury	G.													
8760, ate be executed hysician and the burial-transit			resulting in death)	Last	ì	Due to	(or as a c	consequ	ence of):									
Records, P.O. Box 68760, The law requires that the death certificate be executed te has been signed by the attending physician and sace 2 should be detached for use as the burian-transit		dical			d													-
Box 68 eath certifica attending pt		Physician/Me	IF FEMALE: 23b. Was deceder	at pregnant	230	. If yes, ou									23d. D	ate of delive	ery	
Geath death e atternation		iciai	in the past 12	2 months?			birth 2 nant at tin			□Ectopic p □ Other (sp					N	Month	Day Year	
that the de ed by the a		Phys	9 🗆 Unknowi		1			•	tal 1 - at -			- i- D		23 p. Did tob	20.000 US0 00	atributa to t	he cause of death?	_
dS, F ires tha signed		ò	Part II. Other sign	meant condition	ms contr	buting to d	eath but i	not resu	iting in the u	inaeriying c	ause give	en in Pan i	l.		s 2 No		pably 4 Unknown	
Record he faw require he has been si		etec												24a. Wasa	n 24b	. Were auto	psy findings available	
Rec he tav e has	J	Completed												autops perforr	۷ Ja	prior to co death? 1 \(\subseteq \text{Yes}	mpletion of cause of	
	5	O.	25. Was case refe	rred to medical								26. Place	e of Death (0	1 ☐ Yes 2 Check only on		1 🗆 163	20110	-
Of VI Physici this cer	5	ToB	examiner? 1 Tes 2	140	Но		Inpatient		ER/Outpatie	nt 3 🗆 D	Othe	er: 4□N		5 ☐ Reside			ý)	
Division of Vita to Attending Physician: after death. Director: Attenthis certification by the funeral director.	5		27. Manner of Dea 1 PNatural	5 🗌 Pendin		28a. Date (Mor	of Injury oth, Day Y	rear)	28b. Time o Injury		28c. Injury Work	K?		d. Describe ho	w injury occ	urred		
Division or Attend after death Director: /		icat	2 Accident 3 Suicide	investig 6 ☐ Could r	not be	28e. Place	e of Injury	/ - At ho	me, farm, st	M reet. factor		Yes 2□		f. Location (St	reet and Nur	nber or Rura	al Route Number,	-
Div after Dira	<u> </u>	Certification:	4 Homicide	determ	Ineu	build	ding, etc.	(Specify)	,	,,			City or Towr	i, State)			
Hospital 24 hours a Funaral I	any mile	edical C	29a. Certifier (Check only											d due to the call at the time, d				
tha tha	naid.	Medi	one) 29b. Signature and	_//			nner state					e number			9d. Date sign			_
Twith of p	3		250. Signature and	1-14		/ 4				1			27					
0 12			30. Name in add	dress of person	the same	plete cau	ise of dea	ith (Item	23a) (Type.	Print))	- 25	-		2005	
10			DR- 57	EPHE		In	17/	4	76	000	DA	LOL	AV.	2 70	1Kom	a PK	mo	
	Sta		31. Date filed (Mo	nth, Day, Year) G 0 4 21	በበፍ	2. 1	Registrar'	s Signat	ture									
Reg	gistra	ar	AU	U V 4 A	UUJ	DUR	in	A	400									_

			For	State of Marylan				ental Hyg	jiene	
			Registrar 1. Decedent's Name (First, Middle, I	act)	Ce	rtificate of Dea		2. Date of Dea	eg. NØ 0 0 5	3. Time of Daare
	Physici	an	MARGARE	,	EN			Month ALIG	Day Yes	
	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, or Locat		7100	4c. County of D	
	*.			LAND Med CT	R	BALTIMORE	3		NIF	+
	Funeral Director			Sex 7. Age (In yrs. 1 M 2 F 48		If Under 1 Year If Un Months Days Hou	urs Min.	B. Date of Birth (Month, Day 02 • 09 •	, Year)	Birthplace (State or Foreign Country) MS
	P		Usual Residence of Decedent 10a. State 10b. County	10c Cit	v. Town or Lo	ocation				10d. Inside City Limits
	daryta f sho	ō	MD N		nmor					1 K Yes 2 □ No
	28a-	rect	10e. Street and Number			10f. Zip Code			log. Citizen of What	Country?
	23a o	aiD	2214 PRESSMAN	STREET		21216			USA	
	ems	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hispania If Yes, specify Cuban, Me	c Origin? (Spec xican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	d within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23a or 28a-f show The Musical Est. ill sett out the Intillised at	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No Spe	ecify:		Specify: 8	IACK.
5-0036	2 hour		15. Decedent's	Education	16a. Dece	dent's Usual Occupation			16b. Kind of Busine	
215	within 72 ene. than "nat	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	life.	kind of work done during DO NOT use retired)				
2121		Соп	11 TH GRADE	NA	3001	AL WORKER			SOCIAL SE	
Maryland	d tal	o Be	17. Father's Name (First, Middle, La JAMES WISE	st)		18. N	dother's Name (First, Middle,	Maiden Sumame) U	NK .
Z	2 should be and Menta ia marked aumatic av	ĭ	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street and No	umber or Rural	Route Numbe	r, City or Town, Stat	e, Zip Code)
	and 2 lealth at m 27 ia har trau		CHARLES GRIFFIA	ITE (SON)	2214	PRESSMAN	ST., B	ALTO .	MO 21216	
altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	20b. F	lace of Disponentery, cre	osition (Name of matory or other place)	Da	te	20c. Location - City	or Town, State
Ë	Pages ment of ant: If it ury or o		`4 □Donation 5 □Other (Spe	GRI	EENMO				BALTO.M	0
Balt	permit. Page Department of important: If any Injury or once.		21. Signature of Funeral Service Lie	ensee	v.	2. Name and Address of F AUGHN C. GRE 51 BALTO, NA	EENE FI TU PIKE	BALTO	SERVICE MO 21	229
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that caused the deati						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	SEPSIS						Onset and Death 48 hrs
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					i wa Kana i wa ka
	<u> </u>	7	Sequentially list conditions, if any, leading to immediate	b. AIUS Due to (or as a conseq	uence of):					unknown
7	nsit	mine	Cause, Enter Underlying	(0. 40 40 40 40 40 40 40 40 40 40 40 40 40						
X,	e be executed sician and e burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dicai		d						
9	ortificate ing phy: a as the	Med	IF FEMALE:							
Вох	eath certific attending pl	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	death 3	□Ectopic pregnancy			23d. Date of Month	delivery Day Year
0	at the de by the a tached t	ysic	1 ☐ Yes 2 XNo 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eatu st	Other (specify)	-			
۵.	that the		Part II. Other significant condition	s contributing to death but not res	ulting in the u	inderlying cause given in F	Part I.	23e. Did to	bacco use contribut	e to the cause of death?
rds	quires in sign uld be	ed by	Cirrhosis					1 □ Y	es 2 K No 3□	Probably 4 Unknown
of Vital Records,	law requir as been si 2 should	Completed						24a. Was a	an 24b. Were	autopsy findings available to completion of cause of
R	The l	EO.						perfor	med? death	
/ita	Phyaician: this certific ral director,	Be (25. Was case referred to medical examiner?				Place of Death			
of V	Phyais this o	2	1 ☐ Yes 2 No		ER/Outpatie				ence 6 Other (S	Specify)
ou c	ding F	ion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Injury at Work? M 1 ☐ Yes		sa. Describe ri	ow injury occurred	
Division	or Attanding after death. Diractor: After in by the fune	fical	3 ☐ Suicide 6 ☐ Could no	be 390 Place of Injury . At he	ome, farm, st			Bf. Location (S	treet and Number of	r Rural Route Number,
Ö	spital or A ours after neral Diran filled in by	Certification:	4 Homicide	building, etc. (Specif	y)	7.54		City or Tow	n, State)	
	To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by	edicai ((Check only 2 Medical Ex	Physician: To the best of my known aminer: On the basis of examina						
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner stated.		29c. License num	nber		29d. Date signed (M	onth, Day, Year)
	T w S			CC1/ 1410		P166	_			2005
•	M		HIROKO B		n 23a) (Type.	Print)				
	.)	-	HIROKO BECK	22 South Gre	ene s-	k Baltin	nore 1	MD ?	21201	0
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature					
	Regist	rar	AUG 1 9 2	UUS STERRIED PO	· Algo					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** .UCU 7:15 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death University of Maryland Medicel Cente Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 216.36.5229 Usuel Residence of Decedent 1 M 2 F Yrs. Director 06.02.1932 NC Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov clical Examiner must be notified at 1 No 2 No MD N Funeral Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BRADDISH 1022 AVENUE 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ 3 ₩ Widowed 4 Divorced BLACK the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 is marked other than traumatic evant, the Mi Elementary/Secondary (0-12) College (1-4or 5+) LAUNDRY PRESSER 1214 GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LEWIS EATON RUTH MIUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH HARRIS (DAUGHTER) 1306 MANTLE ST., BALTIMORE, mo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or once. ARBUTUS * 4 ☐ Donation 5 ☐ Other (Specify) 08.19.05 BALTIMORE MO 21. Signa ure of Funeral Service License VAUGHN C. GREENE FUNERAL SERVICE auch 5151 BALTO NATL' PIKE, BALTO MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** intracerebra 6 hrs /Medical Due to (or as a consequence of) **Examiner** Due to (ur a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician e attending phys. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death3 Completed by 4 Onknown been sign 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe 1 Yes 1 Yes 2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

Medical h State Registrar

31. Date file (Month, Year)

29b. Signature and title of certifier

30. Name and ad 1 e of person

29a. Certifier

(Check only

Dany Liana

PITTSS

29c. License number

1 Critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

14,05

mpleted cause of death (Ite 23a) -e, Print) 5. Greene St Balthore

1 9 2005

MO

32. Registrar's Signature Double

			1 - For State Registrar	State of M	1aryland			nt of H te of L		ind Me		giene	005	271	136
ij	Physici		1. Decedent's Name (First, Middle, Last) George C. Azza							-	2. Date of Dea Month UGUST	Day	2005	3. Time 6:45	
	/Medic Examin		4a. Facility Name (If not institution, give s		r)		4b. City	, Town, or	Location o		<u> </u>		ounty of Death	1	
\$		16 EX	3813 Cranston Av		han da uma l	a ad latinda da di		altin	107e If Under 2	DA Hire I			N/A		
	Funeral Director		212-30-3845	M 2□ F	Age (In yrs. Ia	Yrs.	Months		Hours	Min.	B. Date of Birt (Month, Day July 11	Year) 9	34 Mar	place (State ntry) LYLand	or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	City Limits
	Mary I sho	tor	Maryland N/A			Balt	imor	0.							s 2 No
	or 288	irec	10e. Sireet and Number					p Code				10g. Citize	n of Whal Cou	ntry?	
	ath wi	rai	3813 Cranston Ave						212				S.A.		
	ter de Iteme	Funeral Director	11. Marital Status 1 ★ Never Married 2 Married	 Was Deceder Armed Forces Yes 2 	5?	S. 13.	Was Dece If Yes, spe	dent of His	spanic Orig n, Mexican	in? (Spec , Puerto Ri	fy Yes or No- can, etc.)	. 14	 Race - Ameri Black, White, 		
920	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1 🗆 Yes	2 X No	Specify:			S	pecify: Wh	ite	
2-0	filed within 72 hours after death with the Maryland Hygiene. Aher then "natural", or fleme 23a or 28a-f show ther the Medical Exaculation that be undified at	Completed	15. Decedent's Educ (Specify only highest grade			16a. Dece	dent's Usi kind of w	ial Occupa	tion uring most	of working	,	16b. Kind	of Business/Ir	dustry	
121	within ane. then	mpi	Elementary/Secondary (0-12) 12th Grade	College (1-4o	r 5+)		oo not i ilor	ise retired,				CP	othing		
d 2	Hygie other	Be Co	17. Father's Name (First, Middle, Last)				non		18. Mothe	r's Name (First, Middle,				
ylan	Mental Mental arked atic ev	To B	George C. Azzar								V. W				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Meniat Hygiene. Important: if Item 27 is marked other then "natural", or Iteme 23s or 28s-f show any Injury or other traumatic event, Ite Medical Exacting Instal by Incilled at an Once.		19a. Informant's Name/Relationship (Ty) Mrs. Mary J. Carpe		usinl						Route Numbe ltimore		own, State, Zij 21236		
ore,	of Heal	1	20a. Method of Disposition		20b. PI	ace of Dispo	sition (Na	me of	1	Da		•	tion - City or T		
Baltimore,	Pages ment of h tant: If the lury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation / # 🗓 Other (Specify)	Entombme		rkwood	Mau	soleu	m 8	/20/2	2005 1	Balti	more. N	laryla	nd
Ball	permit Depart Import any In		21. Signature Wineral I wice License	99							nunek 1 Etimore		al Home	s	
		1	23a. Part1. Enter the disease, or complishock, or hear failure. List only or	cations that caus	ed the death		-						21236	Approxim	ate
200	Physician		Immediate Cause (Final disease or condition											Onset and	
	/Medical Examiner		resulting in death)	Due to (or a	is a consequ	ience of):									
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8760,	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or a	is a consequ	ience of):									
687	ificate g phys	edical							1.4	_					
Вох	death certific e attending p id for use as i	an/M	200. Has decedent pragnant	3c. If yes, outcom			TEctonic r	regnancy				23	d. Date of deliv	,	
о. П	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown			Other (s		-				Month	Day	Year
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ords	w require been sig should b	ted t									1 🗆 Y	'es 2 5	No. 3 Prol	bably 4	Unknown
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Ž	Physician: r this certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 Yo	ospital: 1 ☐ Inpa	tient 2 🗆 I	ER/Outpatier	nt 3□ D	OA Othe			Check only o		Other (Special	£.,1	
J Of	og Phy ter thi		27. Manner of Death	28a. Date of In	jury	28b. Time or		28c. Injury Work	al		d. Describe h			<u>y)</u>	
SÌOI	Attending Physician: r death. sctor: After this certific by the funeral director,	catic	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗆 Y	'es 2 □ 1	10					
Division	after of Direct of in by	Certification:	4 Homicide determined	28e. Place of I building,	njury - At ho etc. <i>(Specify</i>	me, farm, str	eet, facto	y, office		28	f. Location (S City or Tow	Street and I n. State)	Number or Run	ul Route Nu	mber,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai C	29a. Certifier Circle Only 2 Medical Examile	ier. On the basis	or examinat	wledge, death	n occurred	at the tim	e, date and	d place, an	d due to the o	cause(s) ar	nd manner as s	tated.	(s)
	To the within 2. To the complet	Med	29b. Signature and title of certifier	and manner	stated.			c. License					signed (Month,		
)	F > F 0			S				2	334	41			st 19,		
	141		30. Name and address of person who co	mpleted cause of	death (Item	23a) (Type,	Print)								
1	Sta	te	Dr. Kenneth William 31. Date filed (Month, Day, Year)	32 Regis	N. KC		Kd.	Bal	timor	e, MI	21228				
	Registr		AUG 1 9 2005	Real	e de	Lines	all of								

			For State		State	of Maryla		artment of F		nd Mer		jiene	105	271	37
			1. Decedent's Name	e (First, Middle,	Last)					2.	Date of Dea	th	<i>y</i>	3. Time	
	Physicia				Ro	odolfin	ıa	Alavez			Month	Day	Pear	11:4	OPM
	/Medic Examin		4a. Facility Name (I	f not institution,				4b. City, Town, o					unty of Death		
			FRANKLIN	SQUAR	E HOSPI				EDALE				ALTIMO		
	Funeral Director		5. Social Security N 234-04-		6. Sex 1 □ M 2 🛣 F		. last birthday Yrs.	Months Days	If Under 2 Hours	Min	Date of Birth (Month, Day EB 3,	1 96	Cour	olace (State htry) X 1 C O	or Foreign
			Usual Residence of				-							Od. Inside	City Limite
with the Maryland	r 28a-f show a notified at	٥.	10a. State MD	10b. County	altimor	1	city, Town or L		ltimo	re					s 2X No
th the N	or 28a-	Funeral Director	10e. Street and Nu	mber				10f. Zip Code			1	10g. Citizer	n of What Cour	ntry?	
th wi	23a	raic	5631 I	Daybre	ak Teri				21206				Mexi		
A Aeath	or Items	une	11. Marital Status	·	Armed	ecedent Ever in Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Orig an, Mexican,	in? (Specif Puerto Rid	y Yes or No- an, etc.)	14.	Race - Americ Black, White,		
ALAVEZ RODOLFINA Baltimore, Maryland 21215-0036		by	1 ☐ Never Marr 3 ☐ Widowed		If Yes,	s 2 X No Give r Dates:		1 XYes 2 No	Specify:	Mexi	can_	Sp	Hi:	span	ic
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ind he	f Health and Mental Hygiene. item 27 is marked other than "n other traumatic event, Ire Madi	Be	17. Father's Name	_		- D-5-	_				First, Middle,				
2 aryla	d Mer narke	은	19a. Informant's N	Senon	Martine	z Baños		ling Address (Street		elica r or Rural F			Ramos Town, State, Zip	Code)	
Mal	traut		Ramiro			sband	4	Daybre				_	ore,		21206
re, N	f Healitem 2		20a. Method of Dis	sposition		20b.	Place of Disc	osition (Name of ematory or other pla		Date			tion - City or To		
A mor	nent o int: If iry or		1 ☐ Burial 2 `4 ☐ Donation		3 □Removal from the secify)	om State Me		ematory,		08/19	/05	Bal	timor	e, MI	D
Balti permit.	Department of Health a Important: If item 27 Is any injury or other tra		21. Signature		Ensee /	on still		rematiti 99 Fred	ns of scills	iety	of M			MD '	21228
	0200		Geor	the disease, or	MacNat complications the	ob at caused the de		nter the mode of dy					ore,	Approxim	nate
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P at se	by the	Phys	9 🗆 Unknow						ia Dard I		23a Did to	phaceo usa	contribute to 1	the cause c	of death?
Division of Vital Records, P.O. Box 6	been signed by the attendin should be detached for use	by	Part II. Other sign	incant condition	ons contributing t	to death but not i	esalting in the	underlying cause g	Vall lit r dit i.	· 		/es 2 🔲			∐Unknown
COL	s beer s shou	Completed									24a. Was		24b. Were aut	opsy finding	gs available
I Re	ate has page 2	mo									perfo	med? 21 X No	death?	2 🗆 No	
ital	certificate rector, pag	Be	25. Was case refe examiner?	erred to medica						of Death (Check only o	ne)			
of V	this co	2	1 Yes 2		1	X Inpatient 2 ate of Injury	☐ ER/Outpati 28b. Time	ent 3 DUA		to be a second	e 5 Resid		Other (Speci	fy)	
On o	h. After funer	tion	1 Natural 2 Accident	5 Pendir investi	g (A	Month, Day Year)) Injury	W	ork?]Yes 2 ☐ l						
Visi	within 24 hours after death. To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2	Certification;	3 Suicide	6 Could	not be	lace of Injury - Al	t home, farm,	street, factory, office		28	f. Location (S City or Tox		Number or Rur	al Route N	lumber,
الله الله	ral Di			ed a succ					il - dete on	d = 0=0 ==	d due to the		ad manner as	rtatod	
Hoso	within 24 hours at To the Funeral D completely filled it	Medical	29a. Certifier (Check only one)	2 Medical	Examiner: On the	o the best of my k ne basis of exam manner stated.	ination and/or	ath occurred at the investigation, in my	opinion, dea	ith occurred	at the time,	date and p	lace, and due	to the caus	e(s)
	vithin Fo the	Me	29b. Signature an	d title of certifie		0 1	, 01		nse number			29d. Date	signed (Month	Day, Year	r)
	1	1	12	rem.	W	nesido	ntfr	ysician	RESE	0000	0	8	11710	5	
1	0		30. Name and add	eth.	who completed	cause of death (I	tem 23a) (Typ	e, Print)	0 10	100	7.11-0	F . A	7 717	27	
_	l l		Dr. DANI		ERRY, G	1000 FRA	NKUN :	SQUARE T	DKIVE	, BAC	IMOR	, 19	11 212)/	
	St: Regist	ate rar	31. Date filed (Mo	AUG I	9 2005	2. Hogistrar's Sig	15 1	GORAGA							

CPM 05-05479 Lawrence Alston

Amend item/20a b, perith, G846, 8/23/15 The State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** awrence 13, 2005 <u>August</u> 18:55/Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3342 Avondale Avenue Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 212-48-1137 Usual Residence of Decedent 12-48-113 1**X** M 2□ F Yrs. Director lano 2 should be filed within 72 hours after death with the Maryland and Menlai Hygiane. 10a. State 10b. County 10c. City, Town or Location ir then "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Directo Varyland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42 212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ lfYes, Give Year or Dates: Specify: Specify: Blac 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) arehouseman ommer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny fully or other treumatic event space. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 9 19a. Informant's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) Ave, twonda 0 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Trinity Cemetery Burial 2 Cremation 3 Removal from State 8/22/2005 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility Joseph L. Russ Funeral Hom 2222 W. North Ave. Balto. Md Extions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Parm. Enter the disease, or complishock, or heart milure. List only or Approximate Interval Between Onset and Death y pertensive Arterioscleratic Immediate Cause (Final disease or condition resulting in death) Physician ardio Voscular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attanding p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9□ Unknown 9 Unknown signed by I Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should t Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of dealin?

Yes 2 \[\] No 24a. Was an hes autopsy performed? page After this certificete 2□No Yes director, 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 XOther (Specify) SCENE ٥ 1 X Yes 2 □ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by 4 T Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical 29b. Signatu titte of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 14, 2005 30. Nama a cause of death (Item 23a) (Type, Print) w 111 Penn Street, Baltimore, Maryland 21201 M 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 9 2005

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9	Funer Funer tely fill	Medical	(Check only 2 Medical Examin	ician: To the best of my knower: On the basis of examina	owledge, death	occurred at the time restigation, in my of	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
4	within 24 h	Mec	one) 29b. Signature and title of certifier	and manner stated.		29c. License				signed (Mont	
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	10		30. Name and address of person who cor	mpleted cause of death (Item	n 23a) (Type,	Print)			1		ghad
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 9 2005	32. Registrar's Signa	ature form	a spirasl	- Rie	nd allitu	>L-n	Ma	ghad

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Thelma Loveta Asbury /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 59 uace 1105 pital
6. Sex 7. Age (In yrs. last birthday) ROSCOAIC
If Under 1 Year If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 M 200 Yrs. 223-42-4117 72 July 22,1933 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2000 Director Maryland Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 Bennett Road 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★XNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XXX þ Specify: 3€Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Educator School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emory Hill Cora Kiser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7411 Baylor Avnue, College Park, Maryland 20740 19a. Informant's Name/Relationship (Type, Print) Preston Asbury (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Rurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Holly Hill Mem. Gard. Aug. 20, 2005 Baltimore, Maryland 21. Signature Funeral Server is see 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease Condition ritical Hortic resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 0 that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐ Yes 2 ☐ No 1 Yes 21**2** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner The law requires that the death certificate be executed nding physicien and use as the burial-transit Box 68760, use as the

Funeral

Director

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permit. Pages 1 and 2 Department of Health a Importent: If Item 27 le any injury or other tret once.

the Maryland

Baltimore, Maryland 21215-0036

: After this certifical funeral director, I the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

Division of Vital Records,

Examine Physician/Medical þ Completed Be 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

29b. Signature and title of certifier MIMD

29c. License number 29d. Date signed (Month, Day, Year) 00062373 AUGUST 17,2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paz 9000 Franklin Square Drive Baltimore, MD 21237 Dr. Kobert Aldo

State Registrar

32. Agistrar's Signature 31. Date filed (Month, Day, Year) AUG 1 9 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. 2. Dale of Death 1 Decedent's Name /First Middle Last 2005^{Year} Month **Physician** Helen Irene Ash 14:20 M August 14, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3501 Forest Edge, #3F Silver Spring Montgomery If Under 1 Year Months Days If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Dec. 12, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex ^{Year)} 1919 **Funeral** Months 1 □ M 2 🕅 F 578-05-1668 85 Dec. Maryland **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f show traumatic avant, the Medical Examinar mat be notified at 1 ☐ Yes 2 No Silver Spring Directo Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 3501 Forest Edge #3F 20906 United States 236 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Itams 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiena. Itam 27 is marked othar than "netural", or Itai 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White <u>م</u> 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary C. Whiteford Ernest Brower 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 109 Hamlet Park Drive, Clyde, North Carolina 28721 Jean Santucci/Daughter Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
Montgomery
Crematorium, Inc. permit. Pages 1
Department of H
Importent: If its
any injury or ot August 16, 2005 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc 300 West Montgomery Ave., Rockville, MD 20850-2805 of Funeral Serylce Licensee Inc. M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrest Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No ō 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Tyes 2 No 3 No Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has director, page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖾 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 10 1 x Yes 2 No 5x Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours a 1 🔀 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier D33067 August 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18109 Prince Philip Drive #225, Olney, Maryland 20832 Gallino, M.D. Robert A. 31. Date filed (Month, Day, Year) 32. Registras Signature State AUG 1 9 2005 Registrar Weller.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item 22 per fh G846 8-19-05 has of Death

Red. No. Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) a M **Physician** A. BRACKETT CHARLES /Medical 4c. County of Death Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner LAMURE veypord Greneral NA Date of Birth (Month, Day, 7 Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1**00** M 2□ F 82 MD 12.02.1922 215.14.4001 Director Usual Residence of Decedent 10d Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-1 ehow other traumatic event, the Mudical Examiner must be notified at 1 XYes 2 No BALTIMORE Director am 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö STREET 21216 USA 2600 N. LONGWOOD itema 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 (X)Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 X No Specify. ltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced "naturei", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) US POSTAL SERVICE CLERK 12 TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Heath and Mental Important: if Item 27 is marked eny injury or other traumatic evolves. MARY BROOKINS JAMES BRACKETT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (WIFE) BRACKETT 2600 N. LONGWOOD ST., BALTO. MD 21216 MILDRED 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State BALTO. MD 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS yee Vaughn C. Greene Funeral Service 5151 Balto. Natl Pike, Balto., MD 21229 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cayse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier leath (Item 23a) (Type, Print) cause of General Hospita 30. Name and address a person who complete

Registrar DHMH 17 Rev 1/2001

State

Jake

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	Physici /Medio	cal	1. Decedent's Name (First, Middle Phyllis Kay Bi	ly	mhasl		4h Cihi To	um or Logation of Day	2. Date of De Month August	_	
	- Funeral	er	4a. Facility Name (If not institution Gilchrist Cente 5. Social Security Number 212-40-6132	er	7. Age (In yrs.	last birthday) Yrs.	If Under 1	Wn, or Location of Deat TOWSON Year If Under 24 Hrs Days Hours Min.	8. Date of Bir	Baltimo	ore County Birthplace (State or Foreign Country) altimore, MD.
		tor	Usual Residence of Decedent 10a. State 10b. County	rd County	10c. Cit	y, Town or Lo	ocation			7,1312	10d. Inside City Limits 1 □ Yes ŽŽNo
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5-0036	72 hours after of "netural", or Iter	by	1 Never Married 2 Marr 3 Widowed 4 Divorced 15. Decedent (Specify only highes	ed 1 Tes If Yes, Gin Year or D	2 XNo	16a. Dece	1 ☐ Yes 2 ☐	No Specify:		Specify:	White, etc. White
Baltimore, Maryland 21215-0036	be filed within tal Hygiene. d other than "	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle,	College (1	,	life.	DO NOT use	nscription	ist	Health Maiden Sumame)	n Care
Maryla	s 1 and 2 should be filed to filed health and Mental Hygis I lem 27 is marked other troumatic event, II other treumatic event, III	Tof	Arthur Joseph I 19a. Informant's Name/Relational Mr. Craig B. Mo	nip (Type, Print)	on)			Kathryn Greet and Number or R Sland Road	ural Route Numb	 VanSlyke For City or Town, St. Maryland 	
timore.	permit. Peges 1 end 2 Department of Health Importent: If Item 27 I any Injury or other tre <u>phce</u> .		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)	3 □Removal from pecify)	State 20b. P	Place of Dispo emetery, crea ans Fur	osition (Name matory or othe neral C	of er place) Chapel Aug.	Date 19,2005	20c. Location - Ci	ty or Town, State
Bal	permi Depe Impo any li		21. Signature of Funeral Service 23a. Pan. Enler the disease, pr shock, or heart failure. Ust	-F.	aused the death						Approximate Interval Between
5, 0825 68760, F	w ~ =	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a		uence of):		Ancer			Onset and Death
2005 Box	at the death certific by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknøwn		irth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic preg Other (s <i>peci</i>			23d. Date of Month	•
	w requires that been signed t	b	Part II. Other significant condition	ns contributing to de	eath but not rest	ulting in the u	nderlying caus	se given in Part 1.	1 🗆	Yes 2 Nio 3	ute to the cause of death? Probably 4 Unknown
Pryuls.	ysician: The law is certificete has t director, page 2 s	Be Completed	25. Was case referred to medical examiner?					:	24a. Was auto perfo 1 Ves ath (Check only of	psy prio ormed? dea 2 No 1	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
βλιψ .βιψωιλ. Θ Division of Vital Records,	Attanding Physician: r death. sctor: After this certific. by the funeral director,	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r	g 28a. Date (Mont	npatient 2 of Injury th, Day Year) of Injury - At ho	28b. Time o Injury	f 28c	Injury at Work?		how injury occurred	(Specify) (40 Spice
Div	the Hospitel or Attandin 24 hours after deatl the Funeral Director: mpletely filled in by the		4 Homicide determ	g Physician: To the	ng, etc. (Specifi best of my kno	y) wledge, deatl	h occurred at	the time, date and place	City or Ton	wn, State) cause(s) and mann	er as stated.
	To the Hospital (within 24 hours at To the Funeral D completely filled i	Medical	29b. Signature and title of certified	Thury V	ler stated.	, cv	29c. L	icense number	and at the time,	29d. Date signed (Month, Day, Year)
•	15		30. Name and address of person A R L 31. Date filed (Month, Day, Year)	who completed caus	e of death (terr	1 23a) (Type,	Print)	ile St. E	Palto 1	nd 212	04
	Sta Registi		AUG	1 9 2005	Charles Signa	H.	Garte				

08/18/2005 0825

			1 - State Amend Iter	n 5	_							Mental Hy			27144
	Dhuniai		1. Decedent's Name (First, Middle									2. Date of De	ath Day	Vear	3. Time of Death
	Physici /Medio					l Bono	sky	,				August	16,	2005	3:11 P M
	Examin	er	4a. Facility Name (If not institution					4b. City,		Location	of Death			County of Dea	
			Montgomery Gen				loos historia	lf l Inde	O J	Iney	24 Hrs	Date of Bir		ntgom	
	Funeral Director		5.296 586 0740 216-36-0740	6. Sex	M 2□F	62	s. last birthday Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da April 3	, 194	3 Per	ithplace (State or Foreign Country) insylvania
	and and		Usual Residence of Decedent 10a. State 10b. County			10c. C	City, Town or L	ocation							10d. Inside City Limits
	Maryl f sho	টু	Maryland Montg	omer	v		1	Potoma	3.C						1 ☐ Yes 2 ☒ No
	r 28a	Directo	10e. Street and Number		J				p Code				10g. Citiz	en of What C	Country?
	th with	aiD	8212 Jeb Stua	rt F	load				208	354			Unit	ed Sta	ates
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dapartment of Health and Mental Hygiane. Importent: if Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show any injury or other traumatic event, Ire M. dical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 図 Marr 3 Widowed 4 Divorced		2. Was Dece Armed For 1 12 Yes If Yes, Giv Year or Da	rces? 2 🗌 No		Was Dece If Yes, spe 1 Yes				ecify Yes or No Rican, etc.)		4. Race - Am Black, Wh Specify:	nencan Indian, lite, etc. White
21215-0036	n 72 ho "natur	Completed	15. Deceden (Specify only highe	's Educ	ation completed)		16a. Dece	edent's Usu e kind of wo DO NOT u	ial Occup	ation during mos	st of work	ring	16b. Kin	d of Busines	s/industry
2	within ane. then	дшо	Elementary/Secondary (0-12)		College (1	-4or 5+)		iter A					Fede	ral G	overnment
פַ	il Hygis other onther	Be C	17. Father's Name (First, Middle,	Last)					Ī	18. Moth	er's Nam	e (First, Middle	, Maiden S	Sumame)	
<u>a</u>	ould be f Mental H arked of	To B	Phillip Bonosk	У						J	ean	Gorbach			
Maryland	2 should and Men Is marke sumatic	ľ	19a. Informant's Name/Relations			_		-				al Route Numb			
	1 and 2 Health tem 27		Patricia A. Tom	lins	son/Wii					t Ro		Potomac			
0	Pages 1 nent of H ent: If Itel ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		moval from S		Place of Disp cemetery, cre	matory or	other plac	(e)		st 18,			r Town, State
Baltimore,	it. Pa rtmen rtent: njury	,	* 4 □Donation 5 □ Other (S 21. Signature of Funeral Service		_	Cı	ntgome			-		05	Beth	iesda,	Maryland
Ba	permit. Dapartn Importe any inju		21. Signature of Furieral Service	LICONSOI		M00	R R	obert 00 Wes	A. :	Pumph	rey	Funeral Ave., R	Home ockvi	e/Rock 11e, M	ville, Inc. D 20850-2805
Г			23a. Part1. Enter the disease, or shock, or heart failure. List	comptic only one	ations that ca cause on ea	aused the de ach line.	ath. Do not er	nter the mo	de of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a.	Acut	te Car	diopul	nonary	y Fai	llure					Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as a conse	equence of):								
ь		<u>-</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b.		or as a conse	equence of):								
	ured 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ς .	,		,,-								
oʻ.	te be executed ysician and ie burial-transit	Exa	resulting in death) Last	C.	Due to (or as a conse	equence of):								
1760,		Ical		d.											
99 2	ertifica ling pt e as t	Med	IF FEMALE:												
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23		inth 2 ☐ Fe ant at time of	tal death 3	□Ectopic p □ Other (s					23	3d. Date of de Month	elive ry Day Year
<u>ري</u>	s that ned b e deta	y Pi	Part II. Other significant condition	ons cont	ributing to de	ath but not re	sulting in the	underlying	cause giv	en in Part	l.	23e. Did	tobacco us	e contribute	to the cause of death?
ğ	equire en sig ould b	edt	Myocardial Di	seas	e							1 🗆	Yes 2 🔀	No 3□F	Probably 4 Unknown
Records,	The law re te has be age 2 sho	Completed	Osteoarthriti	S	<u> </u>	 						24a. Was auto perfe 1 \sum Yes	psy ormed?	prior to death?	autopsy findings available occurpletion of cause of
īg	lan: rtifica ctor, p	Be C	25. Was case referred to medica examiner?							26. Plac	e of Deat	h (Check only			
<u>></u>	hyaic his ce I dire	To	1⊠ Yes 2 No	Ho		<u> </u>	☐ ER/Outpatie	ent 3 D	OA Oth	er: 4□N	ursing Ho	ome 5 Resi	dence 6	Other (Sp	ecify)
Division of Vital	Attending Phyaiclan: or death. ector: After this certifics by the funeral director, p	Certification;	27. Manner of Death 1 XNatural 5 ☐ Pendir 2 ☐ Accident investi		28a. Date o (Mont	of Injury h, Day Year)	28b. Time Injury	of M	28c. Injur World	yat k? Yes 2 □	No	28d. Describe	how injury	occurred	
Visi	r Atten er deat rector: by the	tifica	3 Suicide 6 Could 4 Homicide determ	not be	28e. Place	of Injury - At	home, farm, s	treet, factor					Street and wn, State)	Number or F	Rural Route Number,
	ospitel or hours eft unerel Di ly filled in		29a, Certifier 1 ⊠ Certifyi r	o Physi				46	d						
	I 4 II 0	Medical	(Check only 2 Medical one)	Examin	er: On the ba	asis of exami	nation and/or i	nvestigation	n, in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	date and p	and manner a place, and du	as stated. ue to the cause(s)
	To the Vithin 2 To the complet	Σ	29b. Signature and title of certifie	9 Om	200	200		29	-	e number	71		29d. Date	signed (Mor	7 2.005
ì	int's	1/	30. Name and address of person	who cor	npleted caus		em 23a) (Type	, Print)			•		, any	VVV	., 5555
	10/		Roger F. Leona						Lip D	rive	, 011	ney, Ma	rylan	d 2083	32
	Sta		31 Date filed /Month Day Year		32 D	egistrar's Sig	nature	AP.	M. 1						
	Regist	rar	AUG	T 2	2000	Allen	الله من	JAN CANCE							

		1	For State Registrar	State of M	Maryland / De	partment of F ertificate of			iene 2005	27145
			1. Decedent's Name (First, Middle	e, Last)	**			2. Date of Death Month		3. Time of Death
	Physici /Medic		Henr	y Joseph	Bruggeman			August		6:40 A M
	Examin		4a. Fecility Name (If not institution		*	4b. City, Town, o	r Location of Death	1	4c. County of Deat	h
			Genesis Herita				dalk			ore Co.
	Funeral		5. Social Security Number	6. Sex 7. / 12∏ M 2□ F	Age (In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,		thplace (State or Foreign buntry)
	Director	-	215-16-2658 Usual Residence of Decedent		83			July 12	,1922 M	laryland
	yland 10W		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
	Mar Mar	ţċ	Maryland	Baltimore	ļ		Dundalk			1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	ng. Citizen of What Co	ountry?
	23a		8169 Kavana	igh Road			21222		United St	
36	n 72 hours after death with the Maryland "naturel", or liems 23a or 28a-f show salical Ent-liner mant be notithed at	by Funeral	11. Marital Status 1 X Never Married 2 Marria 3 Widowed 4 Divorced	If Yes, Give	No	 Was Decedent of H If Yes, specify Cub. Yes 2 No 		pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify:	e, etc.
Ö	sture	ed	15. Deceden	it's Education	16a. De	cedent's Usual Occup	pation		16b. Kind of Business	White /Industry
215	c	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4c	iii	ive kind of work doné e. DO NDT use retire	during most of word)	rking		
212	filed within Hygiene. other then "ant, the Men	mo.	6 Years	College (1-40	, I	rehousema	n		Steel Com	pany
b	m	Be C	17. Father's Name (First, Middle,	Last)			18. Mother's Nan	me (First, Middle, M	Maiden Sumame)	
/lai		2	William A. B	ruggeman			Mary	L. Dres	sel1	
Maryland 21215-0036	2 sho and ls me		19a. Informant's Name/Relations						City or Town, State, 2	
	교육 2 급	1	Barbara Baker	/ Siste		.69 Kavana	Jh Road			21222
Baltimore,	Pages 1 ar nent of Hea ent; If item ury or othe		20a. Method of Disposition 1 Darial 2 Cremation	3 □Removal from Sta	cemetery	sposition (Name of crematory or other pla	сө)	Date 2	20c. Location - City or	Iown, State
ţ	nit. Pa artmen ortent; injury		4 Donation 5 Other (S		Hillton	Service (.9/2005	Towson, M	aryland
Bal	permit. Pages Department of Importent; If it any injury or once.		21. Structure of Funeral Service	· Car	20	7922 Wise	Funeral Ave. D	undalk, M		nc. 21222 Approximate
	Priyoician //Medical Examiner	dical Examiner	23a. Part Inter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or C.	PIRAT	ORY FI E CHRON	AILUR	E	TIVE DISENSE	Interval Between Onset and Death
O. Box 68	The law requires that the death certificate be executed tate has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death t at time of death	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of de Month	livery Day Year
ds, P.	uires that n signed b	þ	Part II. Dther significant conditi	ons contributing to deat	h but not resulting in th	e underlying cause giv	ven in Part I.		pacco use contribute to	o the cause of death?
Vital Record	The law requir ate has been single 2 should	Completed			·			24a. Was ar autops perform	y prior to	utopsy findings available completion of cause of
ita		Be C	25. Was case referred to medica	al			26. Place of Dea	ath (Check only on		
\(\)	Physicien: this certific ral director,	10	examiner? 1 □ Yes 2 [No	Hospital: 1 ☐ Inpa	atient 2 ER/Outpa	itient 3 DOA Ott	her: 4 Nursing H	fome 5 ☐ Reside	ence 6 Other (Spe	icify)
ion of	itending Pr death. ctor: After th the funeral		Z _ Nooldon	igation	njury 28b. Tin Day Year) Inju	ry Wo	ny at irk?] Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	lel or Atte s after de el Directo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ningd 288. Place of	Injury - At home, farm etc. <i>(Specify)</i>	, street, factory, office		28f. Location (Sti City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medicai (29a. Certifier 1 ertifyi (Check only 2 Medical	ng Physician: To the be I Examiner: On the basi and manner	s of examination and/o	eath occurred at the ti r investigation, in my o	me, date and place opinion, death occu	e, and due to the caurred at the time, da	ause(s) and manner as ate and place, and due	s stated. a to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certific	er		29c. Licen:		_	9d. Date signed (Mont	h, Day, Year)
•			Saurndu	11 / wells	MO	1)	27188		0/1/10)
	5		30 Name and address of person	who completed cause of	of death (Item 23a) (Ty	Scel- Pla	ce De	n Dolk	MD 21	222
	St Regist	ate rar	31. Date filed (Month, Day, Year AUG 1 9 20) 005 (32. Reg	istrar's Signature	uli				

		1	State of Maryland / Department of Health and I State Registrar State of Maryland / Department of Death	Mental Hygio	2.005 27146
ı	[®] Physicia		1. Decedent's Name (First, Middle, Last) FOLLIA II CONDED	2 Date of Death	
j.	/Medica		La. Facility Name (If not institution, give street and number) 403) CEDERDALE ROAD 4b. City, Town, or Location of Deat BALTIMORE	h	4c. County of Death
	Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min.		9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	e Maryla e-f sho		MD NA BALTIMORE	1/	1 KLYes 2 No
	with the	Dire	10e. Street and Number 4030 CEDERDALE ROAD 10f. Zip Code 21215		USA
	ier death	Funerai Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
0036	hours aft urel', or	þ	If Yes, Give Year or Dates: If Yes, Give Year or Dates: 162 Decedent's Usual Occupation		Specify: BLACK 16b. Kind of Business/Industry
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygione. It health and Mental Hygione. Item 27 is marked other than "neturel", or Items 23a or 28a-f show other treumatic event, Its Medical Examination ust be notified at other treumatic event.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work done during m		WESTINGHOUSE
nd 21	2 should be filled within and Mental Hygiene. Is marked other then eumatic event, the Me	Be Col	17. Father's Name (First, Middle, Last) 18. Mother's Na	ame (First, Middle, M	Maiden Surname)
Maryland	should be nd Mental n marked matic ev	To	JAMES TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	HANIMO Rural Route Number	
	1 and 2 Health ar em 27 is		EDITH COBBS (DAUGHTER) 4030 (EDERDALE & 20b. Place of Disposition (Name of cemetery, crematory or other place)	O. BAL	D. MD 2125 20c. Location - City or Town, State
Baltimore,			1 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 1 □ Donation 5 □ Other (Specify)		BALTO. MD
Balt	permit. Page Department of Importent: If any injury or once.		21. Signiture of Funeral Service Licensee VAUGHN C. GREEN 5151 BALTO. NATCH	IKE BHU	0. 1110 21229
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinated where the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinated where the mode of dying and the mode of dying.	ac or respiratory arm	est, Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death) Due to (or as a consequence of): Alberts clerche 1000	au T	11000
	- 31	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
,	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
68760	ficate be physicials the bu	edicai	d		
Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 12 No		23d. Date of delivery Month Day Year
P.O.	that the dened by the a	/ Phys	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
Records,	w requires that s been signed b should be deta	ted by	Sewelfe, A	1 □ Y	<u></u>
Rec	sician: The law is certificate has bi	Completed		_ autop	prior to completion of cause of death?
Vital	Physician: 'this certifica	Be	examiner? Hospital: Other	Death (Check only o	ne) Jence 6 □Other (<i>Specity</i>)
of	Phy rald	on: To	1 Yes 2 No		now injury occurred
Division	tence leath tor: the	Certification:	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Number or Rural Route Number, vn, State)
ā	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	al Cer	29a. Certifier (Check only (Ch	ace, and due to the	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death of and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
			JATOM Oserl DO4752°	7	8/18/05
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTUM R. JOSEPH MID 1940 W. BOZT.	st Bac	1MD 21223
	S Regis	tate trar	31. Date filed (Month, Day, Year) AUG 1 9 2005		

			For State Registrar	State of Marylar		artment <i>rtificate</i>			nd Me		ene 9. 12. () ()	5 9	2711.7
		et.	Decedent's Name (First, Middle, Last))_		timouto	0, 2	704177		. Date of Death	g. No. ()	J (3. Time of Death
	Physici		jeanne (enter					(WEUST,	16 21	Year	9:15P M
	/Medio Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City, T	own, or	Location of I			4c. County	of Death	
		¥	Baltimore Washing	ton Medical C	enter	G	1en	Burni	е		Anne	Aru	ndel
ð.	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		If Under 1 Months	Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,	Year)	9. Birthpl Count	lace (State or Foreign try)
	Director		217-24-1485 Usual Residence of Decedent	3 10 2 20 1	77 Yrs.				F	eb. 13	1928		MD
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation						10	Od. Inside City Limits
	Mary	to	Maryland Anne Ar	undel			Pa	asaden	าล				1 ☐ Yes 2 🔯 No
	r 28s	Director	10e. Street and Number			10f. Zip 0				10	g. Citizen of W	/hat Count	try?
	ours after death with the Manylar rel', or Itame 23e or 28e-f ehow Examiner must be notified at		8399 Oak Drive					21122				USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decede	nt of His y Cubar	spanic Origin , Mexican, I	n? (Speci Puerto Ri	fy Yes or No- can, etc.)		- America k, White, e	
36	or It	by FL	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2	M No	Specify:			Specify	Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Itame 23e or 28e-f ehow he Modical Examilier must be notified at	ed b	15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual	Оссира	tion		1	6b. Kind of Bu	siness/Ind	lustry
15	within 72 ho jiene. r then "netur the Medical	plet	(Specify only highest grad	le completed)	(Give	kind of work DO NOT use	done di	urina most o	of working				
212		Completed	12	College (1-4or 5+)		Secr	etar	У			Civil	Se	rvice
9	be filed tal Hygie d other event,	Bec	17. Father's Name (First, Middle, Last)					_		First, Middle, M			
yla	D 6 2 0	은	Ira B. Cent	er				Iren			√harran		
Maryland	and s m	14	19a. Informant's Name/Relationship (T)							Route Number,			
	Heal Heal		Barbara M. Lewis 20a. Method of Disposition	(niece)	988 Place of Dispo				Dat	Annapoli	Oc. Location -		
jo	of of		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crei dar Hi	matory or oth	er place	<i>)</i> A	ug.	22			aryland
Baltimore,	permit. Pag Department Importent: I any injury o		4 Donation 5 Other (Specify) 21. Signature of Juneral Service License	1		2. Name and			200				ome, P.A.
Ba	permit. Departrimporte any inju		1 Lila X	11/						<u>Pasaden</u>			
1	\$ a		23a. Part 1. Enter the disease, or comp shock, or heart ailure. List only	ications that caused the dea								-1166	Approximate Interval Between
A. Marie	Physician		Immediate Cause (Final disease or condition	atherosclero	tic c	artion	115 (1)	Day (1156	21150			Onset and Death
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iλτ√	ad sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due (d) (br as a consec	quence of):								
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687		edic	-	0.									
Вох	death certific e attending pl ed for use as t	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Dectopic pre	ananov.				23d. Date	of delive	ry
	0 0 2	sicia	in the past 12 months?	4 Pregnant at time of a		Other (spe					Mor	ith	Day Year
P.0	that the de led by the detached	Physician/Me	9 Unknown		141 1 14					oo. Didash			41.10
Ś	မန စရ	by	Part II. Other significant conditions co	ntributing to death but not re	suiting in the u	inderlying cal	use give	n in Paπ i.					e cause of death?
of Vital Record	w requir been s should	Completed	Piro I Tour						_	-			
3ec	has l	E E								24a. Was an autopsy perform	р	vere autop rior to con eath?	osy findings available appletion of cause of
B		ဝိ	25. Was case referred to medical					00 81	(D 1 - 1	1 ☐ Yes 2	No 1	☐ Yes	2□ No
₹		0 8	examiner?	Hospital: ↑ ☐ Inpatient 2.X	Outpatie	nt 3 DOA	Othe			Check only one 5 🗆 Resider		r /Snecity	,)
	g Phys er this eral di	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		c. Injury Work			d. Describe how			/
io	Attending R death. ctor: After y the funer	atio	1 XNatural 5 Pending 2 Accident investigation	(Month, Day real)	Injury	М		es 2 □ No	0				
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, st	reet, factory,	office		28	f. Location (Stre City or Town,		er or Rural	Route Number,
Q	urs af irel Di												
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier 1 X Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my kniner: On the basis of examinated and manner stated.	owledge, deat ation and/or in	n occurred a vestigation, i	t the tim in my op	e, date and inion, death	place, an occurred	d due to the car at the time, da	use(s) and mai te and place, a	nner as sta ind due to	ated. the cause(s)
	outhin o the	Med	29b. Signature and title of certifier	and mainter states.		29c.	License	number			d. Date signed		Day, Year)
	- 5 - Ö		KINNY Med	head Durns			1)4	2148	,	0	Wgust,	17. 2	2005
	D		0 a address of person who c	ompleted cause of death (Ite				1	11.	0	011-	, , ,	
	`		PIEMEDO) . USUPA	10 3703 Mou	ntainko	oco V	usud	2016	Ov.	grand	Wgust, 21122		
4	Sta Registi	200	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	200				,			

		•	State Registrar AMEND ITE		-	•	artment of H #1190 :405 alth		nd Me	, ,	2.005	27148	
	Dhysisis		1. Decedent's Name (First, Middle, Last						2	2. Date of Death Month		3. Time of Death	_
	Physicia /Medic		Pete Michael							August	16, 200	5 10:35 A M	
	Examin	er	4a. Facility Name (If not institution, give 1233 Delbert Aven		r)		4b. City, Town, or Dunda		f Death		4c. County of 1 Balti		
	Funeral		5. Social Security Number 6. Se	x 7. A	ige (In yrs. la	ast birthday)	If Under 1 Year Months Days		24 Hrs. 8	B. Date of Birth	9.	Birthplace (State or Foreign	7
	Director		219-18-8104 19	ØM 2□F	79	Yrs.			A	(Month Day, Ye pril 2,	1926 1	Maryland	_
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits	
	e Mar	ctor	Maryland Baltimo	re		Du	ndalk					1 ☐ Yes 2 🔀 No	
	with th	Director	10e. Street and Number 1233 Delbert Ave	21411.0			10f. Zip Code	21222	7	10g.	Citizen of Wha	t Country?	
	death ms 23	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S	3. 13.	Was Decedent of Hi f Yes, specify Cuba			ity Yes or No-	14. Race - /	American Indian,	_
326	be filed within 72 hours after death with the Maryland at Hygiene. A Hygiene. I death than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Executiver mant be notified at event.	by Fur	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates] No	1	fYes, specify Cuba 1□Yes 2【XNO	Specify:	, Puerto Ri	ican, etc.)	Specify:	White, etc. White	
21215-0036	72 hou		15. Decedent's Edu (Specify only highest grad	ucation		16a. Dece	dent's Usual Occupa	ation	of working	161	b. Kind of Busin	ess/Industry	_
	within no.	Completed	Elementary/Secondary (0-12) 10th Grade	College (1-4o	r 5+)		kind of work done of DO NOT use retired 1664 Line				uto Man	ukacturing	
2	filed v Hygie othar i	Be Co	17. Father's Name (First, Middle, Last)			- 100 CI	Deg Dene		r's Name (First, Middle, Mai	iden Sumame)	at furcial verig	
Vlan		ToB	Peter Kryzanowsk	i				Anno	ı K	KRYZANO	MSK1 M	lackow	
	is a s		19a. Informant's Name/Relationship (T) Mr. Robert S. Cro		n)		ng Address <i>(Street a</i> Perry Fo				-		
_	1 an Healt em 2 thar		20a. Method of Disposition	130			sition (Name of natory or other place		Dai	-		y or Town, State	_
Ē	Pages nent of int: If it iry or o		1 XBurial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)		u		slaus Cer		3/24/	2005 B	altimor	e, Maryland	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of unerall Service Licens	600			Name and Address 705 Bela						
ħ.			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that cause	ed the death							Approximate Interval Between	
ı	Physician		Immediate Cause (Final)	a. A1	nal	Li	brillat	iun				Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or a	ıs a consequ	ence of):							
		Jer	Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	ıs a consequ	ence of):							_
10	and transil	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c									_
8760,	cate be executed physician and the burial-transit	ai E)	rosaling in death, 2250	Due to (or a	ıs a consequ	ence oi):							
	ificate g phys as the	ledicai		d									_
Вох	The law requires that the death certifution are been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1□Live birth		death 3[Ectopic pregnancy				23d. Date of	f delivery Day Year	
0.	he dea r the at	ysici	1 Yes 2 No	4□Pregnant 9□Unknown		ath 5	Other (specify)					Day	
٦.	s that t ned by s detac	by Ph	Part II. Dther significant conditions co	ntributing to death	but not resu	Iting in the u	nderlying cause give	en in Part I.		23e. Did tobac	co use contribu	te to the cause of death?	
rds	en sig	ed b	hyper H	usin						1 ☐ Yes	2 No 3	Probably 4 Unknown	
Vital Records,		Completed	Antiwo	yeleiti	WILL	h Cou	nodin			24a. Was an autopsy	24b. Wer prior d2 dear	e autopsy findings available to completion of cause of	ı
E E	Physician: The la r this certificate have ral director, page 2		OF Man case referred to medical					00 Di	-1.0			Yes 2 No	
Ž	ysicia is certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpa	tient 2 🗆 E	ER/Outpatier	nt 3 DOA Oth	0.0		<i>Check only one)</i> e 5 X Residenc	e 6 Other (Specify)	_
Division of	ng Ph Ifter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, L	jury Day Year)	28b. Time o Injury	Worl			d. Describe how	injury occurred		t design.
SIO	ttendi death. :tor: A : the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	280 Place of I	niun, At ho	me farm st	M 1 1	Yes 2 N		of Location (Street	at and Number	or Rural Route Number,	
Ω	al or A s after Il Dirac d in by	Certification;	4 ☐ Homicide determined	building,	etc. (Specify)	eet, tactory, onice			City or Town, S		n rigitar ribbio ribilibor,	
	To the Hospital or Attending Physician: white 24 hours after deals at the deals To tha Funaral Director: Atten this certifica completely filled in by the funeral director;	Medical (29a. Certifier (Check only one) Certifying Phy	rsicien: To the besiner: On the basis and manner	of examinati	vledge, deat ion and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, an	d due to the caus d at the time, date	se(s) and manne and place, and	er as stated. due to the cause(s)	
	To the vithin To the comple	Me	29b. Signature and title of certifier	- i	, ,		29c. License	e number		29d.	. Date signed (A	Month, Day, Year)	
	4		Karmarine	Taw	sm 1	uD	D 0	0357	412	81	17/0	5	
	HTI		30. Name and address of person who c	ompleted cause of	death (Item	23a) (Type,	Print) :	m 300	3 Rei	Uh MC	2123	7	
	Sta R egistr		31. Date filed (Month, Day, Year)	100	strar's Signat	ure	action			•			
	ricgisti	C.I	AUG 1 9 20	UJ Shell	per so								_

amend item/18, perFH, G846, 8/26/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2005 AUGUST 2:39 RALPH FRANKLIN CAREY P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner FREDERICK
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, October) FREDERICK MEMORIAL HOSPITAL FREDERICK 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 34 Mary Land 5. Social Security Number **Funéral** 218-34-3756 1 XM 2 ☐ F 1934 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits rthan "netural", or Items 23e or 28e-f show the Medical Examinar must be notified at Maryland Frederick Knoxville 1 ☐ Yes 2X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1411 Jefferson Pike 21758 U.S.A. death Funeral 12. Was Decedent Ever in U.S Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter nent of Heatilb and Mental Hygiene. ant: If Item 27 is marked other than "netural", or Ite ary or other traumatic event, the Mudical Engine. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation Company 17. Father's Name (First, Middle, Last) 1 KAPher Name Wirs Widdle Maiden Sumame) Edward C. Carey M. Regina Bassford 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1411 Jefferson Pike M. Regina Carey/Wife 20b. Plack How Lille, Maryland 2175 20a. Method of Disposition 20c. Location - City or Town, State Mount Olivet Cemetery Aug. 18, 2005 Frederick, Marylan 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department Important: If eny injury or once. 21. Signature of Fyneral Service Licensee Name and Address of Facility Keeney & Basford Funeral Home MC021 23a. Part. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final 3 days neumonia **Physician** disease or condition resulting in death) HSpira Hon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes tuneral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA this 28b. Time of 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Certification: 28d. Describe how injury occurred Atter 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059283 August, 14, 2005

DHMH 17 Rev 1/2001

Registrar

ORIGINAL ORIGINAL

400 West

7th Street, Frederick, MD 24707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D

32. Registrar's Signature

Addo

0 +

Richard

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Ma	aryland		artment <i>rtificate</i>			Mental H	lygier Rag. 1		271	50
П	Physici	an	1. Decedent's Name (First, Middle, La		ماسىيى	Ch				2. Date of Month		Day Year	3. Time of	
	/Medic Examir	cal	Julie Shaw 4a. Facility Name (If not institution, giv	e street and number)			ance	own, or	Location of De	AUG	US 1	16, 200	5 3:05	Б М
		ier	Saint Joseph 5. Social Security Number 6. S	Medical	Cent e (In yrs. la		If Under 1		T Q W	son		Bal	timore	
	Funeral Director		211-16-3440	□M 2 X)F	80	Yrs.		Days	Hours M		15,	1925 Pe	irthplace (State of Country) nnsylvar	nia
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation	<u></u>					10d. Inside C	ity Limits
	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show the Modical Examinating was benchilled at	ctor	Maryland Baltimo	re	Ti	moniu	n						1 □ Yes	2 💢 No
	vith the	Director	10e. Street and Number				10f. Zip (10g. (Citizen of What C	Country?	
	eath v	erai	2525 Pot Spring 11. Marital Status	Road S-	623	10.1		1093		(Cassit : V	1	U.S.A		
9	after d	Funerai	1 Never Married 2 Married	Armed Forces? 1 XYes 2 1 If Yes, Give W Year or Dates:						(Specify Yes or erto Rican, etc.)	NO-	Black, Wh		
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15-	s within 72 ho piene. r than "natu	Completed	15. Decedent's E (Specify only highest gra	ide completed)		(Give	dent's Usual <i>kind of work</i> DO NOT use	done d	uring most of v	vorking	16b.	Kind of Busines	s/Industry	
212		Com	Elementary/Secondary (0-12)	College (1-4or 5	5+)]	Homema	ker				Own H	ome	
Baltimore, Maryland	d d d o	Be	17. Father's Name (First, Middle, Last							lame (First, Mid		,		
aryle	s 1 and 2 should be f Health and Mental item 27 is marked o other traumatic eve	70	John Eyre 19a. Informant's Name/Relationship (Shaw, II Type, Print)		19b. Mailir	ng Address (Street a	Ru nd Number or		nber. Cit	y Smi or Town, State,	ith Zip Code)	
Ĭ,	1 and 2 Health a tem 27 is		Jane-Eyre M. S	oier Daug	hter		Hampt			Towson	or.		21286	
ore	ges 1 at of He If item or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	netery cre	sition (Name Tatory or oth a ley	of er place)	Date	20c.	Location - City o	r Town, State	
Itim	permit. Pages 1 Department of H Important: If ite any injury or ot once.		' 4 ☐ Donation 5 ☐ Other (Special 21. Signature of the Albert Service Licenters)	y)	Me	emoria	1 Gar	dens	, 8-	22-2005	_	monium	Maryla	
Ва	Depared Important any in		tan Witas			i	L050 Y					Funera		Inc.
П			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each lir	the death.	Do not ent	er the mode	of dying	, such as card	iac or respirator	arrest,		Approximat Interval Bet	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. INTRAC			IEMOR	RHA	GE				Onset and I	
	Examiner			Due to (or as	a conseque	ence of):							12HOU	RS
- 17	/P 15	iner	Sequentially list conditions, if any least to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce of):								
٩	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a conseque	ence of):	 -							
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai E		d										
89 x	ertifica ding ph	/Med	IF FEMALE:	22a If you suiteems	of								1	
Вох	death certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal d	leath 3	Ectopic pred					23d. Date of de Month		/ear
P.O.		hysi	9 Unknown	9□ Unknown										
Records, I	w requires that the been signed by th should be detache	by	Part II. Other significant conditions of	ontributing to death bu	ut not result	ing in the u	nderlying cau	ise give	n in Part I.			use contribute t	o the cause of d robably 4 □l	
Reco	etaw has b	Completed								24a. W au pe	topsy rformed?	prior to death?	utopsy findings a completion of ca	
Viital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Here's I						eath Check on	1	.0 1010	940	
of	shys this al du	: To	1 Yes 2 No 27. Magner of Death	Hospital: 1 ☐ Inpatie	-	R/Outpatien		Other	4 Nursing	Home 5 Re 28d. Describ		6 Other (Spe	ecify)	
ion	Attending r death. Bctor: After by the fune	ation	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	(Year)	Injury	М	Work'	es 2 □ No	200. 2000112	0 110W (11)	ary occurred		
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	Hospital of hours af Funerat D		29a. Certifier 1 Certifying Ph	veician: To the heet o	of my knowl	adaa daath		Africa Aires	- dete end -t-	4				
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical Examone)	ysician: To the best on niner: On the basis of and manner sta	examinatio	n and/or inv	restigation, in	my opi	nion, death oc	curred at the tim	e, date a	s) and manner a nd place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	(11)	N	10	29c. l	License	number			ate signed (Mon		
,			Finde (edle	(3121215	59711		(f-18-1	\ <u>\</u>	
1	5+1		30. Name and address of person who LINDA ADLER M.		eath (Item 2 DSLEF			nie.	TH MA	RYLAND	944	D014		
İ	Sta		31. Date filed (Month, Day, Year)	432. Registra	r's Signatur	Spen		7 WY CD (- 19 19 19 19 19 19 19 19 			et t ant		
	Registr	ar	AUG 1 9 200	filmen	for	A STATE OF					_			

			For State Registrar	State of Man		ertificate of Death		-	005	27151
	Physici	an	1. Decedent's Name (First, Middle		1 2011 -	r	2. Date of Month	Day		3. Time of Death
	/Medic Examir	al	WILLTAM 4a. Facility Name (If not institution		LARK I	4b. City, Town, or Location	n of Death	14 4c.	County of Death	18:39 PM
	Exami	ıçı	UNIVERSITY OF M		CAL CENTE	R BALTEM			NA	
	Funeral Director		5. Social Security Number	6. Sex 7. Age (I	n yrs. last birthday Yrs.	Months Days Hours	14	Birth Day, Year)		place (State or Foreign intry)
	land		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation	V		,	10d. Inside City Limits
	Mary B-f sho	tor	Maryland Ba	Himore	Caton	sville				1 Yes 2 No
	or 28:	Director	10e. Street and Number	Λ		10f. Zip Code		10g. Citi	izen of What Cou	ntry?
	heath v	Funeral	1206 AVI	12. Was Decedent Eve	nuc er in U.S. 13	Was Decedent of Hispanic C	Prigin? (Specify Yes or	No-	14. Race - Ameri	can Indian.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 le marked other then "naturel", or items 23a or 28a-f show other treumatic event, the Medical Evantizational be notified at	by Fun	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? ied 1 ▼Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Clif Yes, specify Cuban, Mexic			Black, White,	etc.
21215-0036	72 hou	eted	15. Deceden (Specify only highes	t's Education	16a. Deci	edent's Usual Occupation e kind of work done during mo	ost of working	16b. Ki	ind of Business/Ir	ndustry
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Dife.	DO NOT use retired)	n s	Ba	Hans	1: L.
	filed within Hygiene. other ther	Be Co	17. Father's Name (First, Middle,	Last)		18. Mot	her's Name (First, Mid	dle, Maiden	Sumame)	CITY
ylar	should be ind Mental marked o	ToB	William -	T. Clark	Sr.		illian	Mo	inn	
Maryland	od 2 sho		19a. Informant's Name/Relations	nip (Type, Print) \ \(\omega\) \(\begin{array}{c} \left(\omega) \\ \omega \end{array}) 19b. Mail	ling Address (Street and Num	A 1	1.00	r Town, State, Zi	Code)
	es 1 and 3 of Health f item 27 r other tr		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place)	Date Catons		cation City or T	own, State
Baltimore,		1	1 Burial 2 □ Cremation '4 □ Donation 5 □ Other (S			· Cemetary	8/18/05	Wisc	dlawn.	Maryland
Balt	permit. Pag Department Importent: I any injury c		21. Signature of Funeral Service		Ĵ	2. Name and Add ssot Fac OSeph L. Kus	SS Funer	-al H	ome.P.A	
	-		23a. Part/. Enter the disease, or	complications that caused the		TZZZW, Nor-H	as cardiac or respirator	y arrest,	1d. 2/12/	Approximate
	Physician		Immediate Cause (Final disease or condition	only one cause on each line.	EO CA	HNCER				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					x /cw 5
		e.	Sequentially list conditions, if any, leading to immediate	b. PULMO		EMBOLISM				I Menth
4	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
,60	ificate be executed g physician and as the burial-transit	a E	resulting in deathy case	Due to (or as a co	onsequence of):					
68760	ificate g phy as the	Aedical	15.55	d						
Вох	The law requires that the death certifiate has been signed by the attending agge 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	□Ectopic pregnancy		4	23d. Date of deliv Month	ery Day Year
0	at the de by the a stached f	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at tim 9☐ Unknown	e of death 5	Other (specify)		-	_	
s, P	res that igned b be deta	by PI	Part II. Other significant condition		ot resulting in the	underlying cause given in Par	t I. 23e. D	id tobacco u	se contribute to t	he cause of death?
ord	w require been si should b		ACUTE RENAL	25-70				☐ Yes 2[÷	□No 3 X Prol	bably 4 Unknown
of Vital Record	The law ate has t page 2 s	Completed	RESPIRATORY	FAILURE			24a. W	tas an utopsy erformed? s 22 No	prior to co death?	opsy findings available empletion of cause of
ital		Be Co	25. Was case referred to medical			26. Pla	1 ☐ Ye		1 🗆 Yes	2 □ No
of V	Phyelcien: r this certific ral director,	၉	examiner? 1 Yes 2 No	Hospital: 1 XInpatient	2 ER/Outpatie		Nursing Home 5 R			(y)
	ing Vfter une	tlon:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig		ear) 28b. Time (of 28c. Injury at Work? M 1 ☐ Yes 2 [28d. Descrit ∃No	oe how injur	y occurred	
Division	of or Attending after death. I Director: After din by the fune	Certification:	3 Suicide 6 Could a	not be an Place of Injuny	- At home, farm, s	treet, factory, office		n (Street and Town, State		al Route Number,
Q	pitel urs a erel l		200 Continue A Continue				1			
	To the Hospitel within 24 hours of To the Funerel I completely filled	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medicel	g Physicien: To the best of re Examiner: On the basis of ex- and manner stated	amination and/or in	in occurred at the time, date a nvestigation, in my opinion, de	and place, and due to t eath occurred at the tim	ne cause(s) ne, date and	and manner as s place, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License number			e signed (Month,	
	1		20 Name and addition	M.D.	h //ham 20:: ~	AU4176435	5T15803	08	114/20	25
	10		BRIAN TULLY			, Print) TREET, BALTI	MORE, MD	212	.01	
193	* Sta		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	and a				
DH	Registr MH 17 Rev 1/2	-3	AUG 1 9	LUUJ SALVES	N. A.	30 GL	S====			

Shannon Combs 05-0 RPD

055	38		rice	State of	f Maryland						•		-egible.	
			1 - For State Registrar	State 0	i waiytana		rtificate				-	_	005	27152
			Decedent's Name (First, Midd	le, Last)				-			2. Date of De			3. Time of Death
	Physicia /Medic		Shannon	Combs							August	16,	2005 ^{ear}	0556 A M
	Examin		4a. Facility Name (If not institution						Location of	of Death			County of Deat	h
			Interstate 68 1				Flin		ne If Under	24 Hrs	0.0		legany	
	Funeral Director		5. Social Security Number	6. Sex 1 🖫 M 2 ☐ F	7. Age (In yrs. las		Months	Days	Hours	Min.	8. Date of Bird (Month, Da Jan.6.	n y, Year) 1067		hplace (State or Foreign untry)
			404–06–1961 Usual Residence of Decedent								_Jan.O,	1907	rei	ıtucky
	trylan thow	_	10a. State 10b. County			Town or Lo	ocation							10d. Inside City Limits
	Ba-fa	Funeral Director	Kentucky Perry		Rowd	ıy	100 70					10. 00		1 ☐ Yes 2 🙀 No
	a or 2	Dir	10e. Street and Number	1.76			10f. Zip						en of What Co	
	Jeath In 23	eral	20325 Ky Highwa	12. Was Dece	edent Ever in U.S.	13.	413 Was Deced		spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		ted Sta 4. Race - Ame	ncan Indian,
9	or iter	Fur	1 ☐ Never Ma <i>m</i> ied 2 🔀 Ma	ned 1 ☐ Yes If Yes, Gir	2 No		If Yes, spec 1 ☐ Yes :		n, Mexicar Specify:	n, Puerto	Rican, etc.)		Black, White	
03	ural',	d by	3 Widowed 4 Divorce	Year or D	ates:								Specify:	White
<u>7</u>	within 72 hours atter death with the Maryland ene. Han "natural", or items 23a or 28a-f show ra Medical Examinar must be notified at	Completed	(Specify only highe	nt's Education est grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	il Occupa rk done d	ation fu <i>ring m</i> os	t of work	ing	16b. Kin	d of Business/	Industry
212	with	omp	Elementary/Secondary (0-12)	College (1	I-4or 5+)		ruck I						Truckin	10
פַ	be tiled tal Hygie d other event, ti	Be C	17. Father's Name (First, Middle	Last)	<u>'</u>					er's Name	e (First, Middle,			-
ylar	should b nd Menta marked umatic s	ToE	Tony Combs						Jea		olliday			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. I the Marylan the marked other than "natural", or items 23a or 28a-1 show other traumatic event, if a Medical Examinar must be notified at	V 3	19a. Informant's Name/Relation Theresa Combs,				-				al Route Numbe	-		
o .	1 and Health sm 27 ther t		20a. Method of Disposition	MITC	20b. Pla	-	osition (Nan		-		Date		ation - City or	
JOH .	ages ant of it: If it y or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State		matory or o. emeter			110 2	0, 2005			
Baltimore,	permit. Pages Depertment of the financiant: If its any injury or of any injury or of any engage.	-	21. Signature of Fune Service	The state of the s	Парт									ral Home
ä	Depermination of the population 12	Hurs 12	pund-	-M01113						, Hazar				
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	complications that of	aused the death.	Do not en	ter the mod	e of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	_ a	luetic	11e	In	Ju	ries)				Onset and Death
E	/Medical Examiner		resulting in death)	Due to	(or as a conseq [™]	nce of):		0						
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9 x	The law requires that the death certilical ite has been signed by the ettending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, out	come of pregnanc	cy						2	3d. Date of deli	iveov
Вох	death s etter d for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live b	oirth 2 ∏ Fetel d liant at time of dea	eath 3[□Ectopic pro □ Other (sp					2	Month	Day Year
0	thet the death	hys	9 Unknown	9□ Unkn	own									
S, D	w requires that been signed t should be det	by F	Part II. Dther significant conditi	ons contributing to d	eath but not result	ing in the u	inderlying ca	ause give	en in Part I.	•				the cause of death?
ord	een s	sted									10`	res 21)	(No 3 Pr	obably 4 Unknown
Sec.	has b	Completed			· · · · · · · · · · · · · · · · · · ·						24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of
a E		e Co	OF Man anno referred to madical	1							1 X Yes	2□No	1 🗚 Yes	2□ No
=	ysician: is certific director,	To Be	25. Was case referred to medical examiner? ¹XXX'es 2 □ No	Hospital	Inpatient 2 E	R/Outpatie	nt 3 DO	Othe			n <i>(Check only o</i> me 5□ Resid		X10ther (Sne	at scene
Division of Vital Records,			27. Manner of Death	28a. Date		8b. Time o	f 2	8c. Injury Work			20d Dosseiba i		annurad	
Sior :	endin sath. or: Af he fur	Certification:	Z D TOOLGOTT	igation 8116	105	Injury	AM .		res 2□			acc	ide ut	otor vehicle
Σ	or Att	ıı	3 Suicide 6 Could 4 Homicide deter	ninnel 286, Place	of Injury - At homing, etc. (Specify)	e, farm, st	. 1	1			28f. Location (S City or Tox	Street and vn. State)	Number or Ru	ral Route Number,
_	pital ours a eral [29a. Certifier 1 ☐ Certifyi	ng Physician: To the	LHELS	ate		MU		1	Mile a	when	V60 F	Intolant, MU
	To the Hospital or Attending Pr within 24 hours atter death To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medica one)	Examiner: On the b	asis of examinatio ner stated.	n and/or in	vestigation.	in my or	oinion, dea	th occurr	ed at the time,	date and	place, and due	to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certific				290	. License	number			29d. Date	signed (Month	h, Day, Year)
	٩		Carol	Halle	1.0 116	1	0	.C.M	.E.			Augu	st 17,	2005
	V		30. Name and address of person	who completed caus	se of death (Item 2	За) (Туре, 111	Print) Penn	Str	eet.	Balt	imore,	Marv	land 21	201
	Sta	te	31. Date filed (Month, Day, Year) 202. F	legistrar's Signatur				,					
it	Registr	- 1	AUG 1 9 2	29	ias St.	Spa	de							
DHM	(H 17 Rev 1/2)	001		1		-								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Yeer **Physician** 2005 4:40 a Aug. Thurmus Custis /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Baltimore Catonsville Caton Manor Under 1 Year onths Days If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Hours XX M 2 F 219-32-7988 78 Director Oct.15, 1926 VA Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Itama 23a or 28a-f ahow Examiner must be notified at 1 ☐ Yes ⊀₩ No Director MD Baltimore n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21225 by Funeral 707 Roundview Rd death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itar any injury or other traumate. Specify: black 1 Never Married 2 Marned black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sr. Plant Operator BGE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nannie Conquest ္က Fred Custis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Roundview Rd. Baltimore, Maryland 21225 Mary P. Custis- wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory
Aug. 16, 05 Baltimore City 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Lig 22. Name and Address of Facility Loudon Park Funeral Home 23a. Part Enter the disease, or complications that ceused the death. shock, or heart failure. List only one cause on each fine. 3620 Wilkens Ave. Baltimore, Maryland 21229 onot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset an Death Immediate Cause (Final disease or condition Physician do resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year be detached for in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably page 2 should been s 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 Yes ② No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Certification: To Be Other: Hospital: 1 Yes 25 No 1 🗌 Inpatient 2 ER/Outpatient AV Nursing Home 5 Residence 6 Other (Specify) 3D DOA this in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled i filled To the Hospital Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plade, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who complet reuse of death (Item 23a) (Type, Print) rumands Ferry Pa 31. Date filed (Month, Day, AUG 32. Registrar's Signature 1 9 2005 State Registrar

			1 - For State Registrar	State of M	-	epartment Certificate			Reg. 2.	05	27154
	Physici	an	Decedent's Name (First, Middle				Davis	2. Date of Do Month AUGUS	Day	Year	3. Time of Death
1	/Medio		Alice 4a. Facility Name (If not institution)	4b. City, To	Davis		7	2005 ounty of Death	02:28 A
	Exami	er	Saint Josep	h Medical	Center		To	OWSON		Balt	imore
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birth	day) If Under 1 Months I	Year If Under Days Hours	24 Hrs. 8. Date of Bi Min. (Month, D	rth ay, Year)	9. Birthp Coul	olace (State or Foreign
	Director		219-22-551 Usual Residence of Decedent	10 W 2021	86 Y	rs.		07 1	7 19	V	A
	yland		10a. State 10b. County		10c. City, Town	or Location				,	IOd. Inside City Limits
	a-fsh	ctor	MD NA		Balti	nore					1火 Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip C	Code		10g. Citizer	n of What Cou	ntry?
	s 23s	eral	5902 Yorkwood	Road 12. Was Decedent	Ever in U.S.	13 Was Deceder	21239 of of Hispanic Ori	gin? (Specify Yes or N		U.S.A Race Americ	
(0	72 hours after death with the Maryland naturel', or items 23s or 28s-f show disal Exercitiser must be multified at	Fun	1 Never Married 2 Mar	Armed Forces	?			gin? (Specify Yes or No n, Puerto Rican, etc.)		Black, White,	etc.
93	rel', o	d by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 L Yes 2L	XNo Specify:		St	becity: B	lack
5	"natu	ete		nt's Education est grade completed)		Decedent's Usual of Give kind of work life. DO NOT use	done during mos	t of working	16b. Kind	of Business/In	dustry
12	within iene. than	Completed by Funeral	Elementary/Secondary (0-12) 12th grade	College (1-4or	5+)	Domes			F	rivat	е
פָּ	a filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle,	Last)				ar's Name (First, Middle	, Maiden Su	ımame)	
ylaı	Menta Menta arked	To	John Thomas					ce Hardy			
Maryland 21215-0036	12 sh h and 7 Is m treum		19a, Informant's Name/Relations					er or Rural Route Numb			
e,	1 and Healt tem 2		Sherry Clark- 20a. Method of Disposition		20b. Place of	Disposition (Name	e of	pad, Balt		tion - City or To	21239 own, State
mo	Pages ent of nt: If i		Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	3 Pemoval from State Specify)	King	, cramatory`or oth Memoria		8/20/05	Rand	allst	own, Md
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Exercitivating the neithbot at ODGe.		21. Signature of Funeral Service				Address of Facilit	the property of the second second second second second second second second second second second second second			
<u> </u>	89589		Tala	Maril	·	4300 W	labash <i>i</i>	Ave, Balt		, Md	21215
			23a. Fart1. Enter the disease, o shock, or heart failure. List	complications that cause only one cause on each l	d the death. Do no line.	t enter the mode	of dying, such as	cardiac or respiratory a	irrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	W	AC ARRES						
Ü	Examiner			SEFSIS		J.					
	R ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequence of):					
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9	ifficate g phy as the	ledic		G				Haranna -			
Вох	eath certific attending p I for use as 1	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	e of pregnancy 2 Fetal death	3 □Ectopic preg	gnancy		23d	I. Date of delive Month	Day Year
В		ysici	in the past 12 pronths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	at time of death	5 ☐ Other (spec	cify)				
<u>α</u>	es that the de igned by the be detached	y Ph	Part II. Other significant conditi	ons contributing to death	but not resulting in	the underlying cau	use given in Part I	. 23e. Did	tobacco use	contribute to th	ne cause of death?
rds	= vo =	ed by	DEMENTIA					1 🗆	Yes 2□N	No 3 ☐ Prob	ably 4 Unknown
of Vital Records,	as b	Completed	SEIZURE DISOR	DER				24a. Was	psy	prior to co	psy lindings available mpletion of cause of
E 2	Th ate pag	Соп						perfi 1 ☐ Yes	2 No	death?	2 No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:	· · · · · · ·		Othor	of Death (Check only		701	
		n: To	1 ☐ Yes 2 X No 27. Manner of Death	1 ☐ Inpati 28a. Date of Inju	ury 28b. Ti		c. Injury at Work?	rsing Home 5 ☐ Res 28d. Describe			Y)
ion	Attending Ph ir death. ector: After th by the funeral	atlo	Z - Mooidont	igation	ay reary III	M M	1 Yes 2	No			
Division	for Attendent efter deatl Director:	Certification:	3 Suicide 6 Could 4 Homicide determ	ningd 200. Flave UI III	njury · At home, lari ntc. (Specify)	m, street, factory,	office	28I. Location (City or To	Street and N wn, State)	lumber or Rura	Il Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 Certifyi	ng Physician: To the best	t of my knowledge.	death occurred at	t the time, date an	d place, and due to the	cause(s) an	d manner as si	tated.
	e Hos 124 h e Fur	edical	(Check only 2 Medical one)	Examiner: On the basis of and manner si	of examination and	or investigation, in	n my opinion, dea	th occurred at the time,	date and pla	ace, and due to	the cause(s)
	To the Hospitel within 24 hours e To the Funeral I completely filled	Me	29b. Signature and title of certific	or O		29c. l	License number		29d. Date s	igned (Month,	Day, Year)
•	(Jul P. C	un fr	n MD	Da	39215		4/1	7 (6)	
	2		30. Name and address of person								
	Sta	te	GAIL CUNNING 31. Date liled (Month, Day, Year	HAM, M.D.	7601 () trar's Signature	SLER DE	RIVE T	OWSON, MAF	YLANI	2120	4
	Registi		AUG 19	2005 Killer	trar's Signature	ENE					_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2005 Month 17, Aug. 11:56 P M Dorothy Lee Dorman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Gilchrist Towson Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. March 13, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 1941 Maryland 64 523-54-0450 Usuaf Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore Lutherville 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number **USA** 21093 9 Barts Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry School. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Education Principal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jane Strasburger Douglas V. Dorman 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3750 Pinebrook Circle #207 Bradeton, FL 34209 Elizabeth Waters/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 08/20/2005 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD. Dulaney Valley Mem. Grdn. of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signatu S. Coster 1050 York Road, Towson, Maryland 21204 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) esse ME TA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Doe to (or as a consequence of) Due to (or as a consequence of) 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐ Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probabfy 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2 X No 26. Place of Death | Check only one

/Medical Examiner Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Deroth.

Dorman,

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

ō

or Items 23a

natural

other then

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any link of other traumatic event pages.

Physician

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Director

Funeral

ğ

Completed

by Physician/Medical Completed certificate To the Funaral Director: After this certific completely filled in by the funeral director, Certification: To Be

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Naturaf 2 Accident

5 Pending investigation 6 ☐ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 ther (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Medical

3 🗌 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d, Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

State Registrar

To the Hospital or Attending

death.

after

within 24 hours a To the Funaral L

31. Date filed (Month, Day, Xear) 9 2005



DHMH 17 Rev 1/2001

			Please 1	ype or Print in I				•	•	e.
			1 - For State Registrar	State of Marylar		rtificate of De			ene 9. N2 0 0	5 27156
B ₁₀	Physici /Medic		Decedent's Name (First, Middle, Last) JEROME		DE	RKETSCH		2. Date of Deat	h	3. Time of Death
	Examin		4a. Facility Name (If not institution, give		· CTD	4b. City, Town, or Loc			4c. County of I	Death
-	Funeral		HOSPICE OF BALTIM 5. Social Security Number 6. Sec	7. Age (In yrs.			TOWSON Under 24 Hrs.	B. Date of Birth		LTIMORE Birthplace (State or Foreign
38	Director		218-22-6106 1X	^{1M 2□ F} 75	Yrs.	Months Days H	Hours Min.	B. Date of Birth (Month, Day, OCT. 17,	1929	Country) NY
poels	how		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
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3	z nous arier veetri wiri trie maryanv atural', or lame 23a or 28a-1 ehow cal Extrairet rust be natilied at	i Dir	10e. Street and Number 4712 BELLE FORTE	ROAD		10f. Zip Code	21208	1	0g. Citizen of Wha	USA
4000	tame 2	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hispa f Yes, specify Cuban, N	nic Origin? (Spec	ify Yes or No- ican, etc.)		American Indian, White, etc.
035	all, or h	by Fi	1 ☐ Never Married 2 🂢 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No S	Specify:		Specify:	WHITE
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	tal Hygie d other	Be C	17. Father's Name (First, Middle, Last)			18.	. Mother's Name (
	5 6 0 U	2	PHILIP 19a. Informant's Name/Relationship (Ty	ena Printl		ETSCH E	BESSIE	Pouto Number		BERNSTEIN
Ma	T Is		RENEE DERKETSCH			BELLE FOR				, ,
2 3	of E		20a. Method of Disposition 1 X Burial 2 Cremation 3 F	lemoval from State	Place of Dispo cemetery, crei	sition (Name of natory or other place)	PARK Da	te	20c. Location - Cit	
Baltimo	. 투운증		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Vicens	OHE		OM MEMORIAL				RSTOWN, MD
מ	Depa Impo eny ir		> Statemy (ettle		Name and Address of POO REISTER				S., INC. E, MD 21208
	hysician /Medical xaminer		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat ne cause on each line. a	veat		uch as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
/bu,		cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or as a consect Due to (or as a consect						
.O. BOX b8/	igned by the attending phys be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn: 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of c	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
ords, P.O	igned t	þ	Part II. Other significent conditions cor	ntributing to death but not res	ulting in the u	nderlying cause given in	n Part I.		ŧ .	te to the cause of death?
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בֿ ב <u>ֿ</u>	ate has	omp						24a. Was ar autops perform 1 Yes 2	y prior	e autopsy findings available r to completion of cause of th?
	is certificate has director, page 2	Be C	25. Was case referred to medical examiner?				6. Place of Death (-	Yes 2□ No
VISION OF VITA	fter this	tion: To	1 Yes 2 No 27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	4 ☐ Nursing Home 28 2 ☐ No		nce 6 Other (w injury occurred	Specify) + 05 p1 C
5 8	i Sign	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str (y)	eet, factory, office	28	If. Location (Str City or Town	reet and Number o , State)	or Rural Route Number,
To the Hospital	the Funer	Medical	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deatl	vestigation, in my opinio	on, death occurred	d at the time, da	ite and place, and	due to the cause(s)
4	S a with	2	29b. Signature and title of certifier	on Rely.	w	29c. License nu	205	F	Date signed (N	Month, Day, Year)
	1		30. Na e and address of person who co	empleted cause of deaty (Iter	п 23а) (Туре, О (— А	Charles.	St fa	Oto and	2,20	×
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 9 20	32. Registrar's Signa	ature	navle				

ORIGINAL

	, 101	artment of Health and Mental H rtificate of Death	
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Viola Dieter 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Death Pay Year 2:35 P M 4c. County of Death
Funeral Director		Parkville If Under 1 Year If Under 24 Hrs. 8. Date of E Months Days Hours Min. 6/20/L	Baltimoe Sirth Pearl Published State of Foreign Country) 1919 Virginia
Maryland a-f show lifted at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Baltimore Parky		10d. Inside City Limits 1 □ Yes 2 ☑ No
ath with the Mar s 23a or 28a-f si mat be rutified iral Director	10e. Street and Number 8910 Emla Avenue	10f. Zip Code 21234	10g. Citizen of What Country? U.S.A.
1036 Duzs after death verifies to tems 234 Exertine fraust 1 by Funeral	1 Never Married 2 Married 1 Yes 27 No	Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiens 77 is marked other than "natural; or traumatic event, it a Medical Exerci- To Be Completed by F	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	odent's Usual Occupation be kind of work done during most of working DO NOT use retired) BCTETATY	16b. Kind of Business/Industry Veterans Admin.
yland; rould be filed Mental Hyg nerked othe natic evant,	17. Father's Name (First, Middle, Last) William Henry Dawson	18. Mother's Name (First, Midd Emma Jane Hai:	le, Maiden Sumame) Slip
ore, Mai ss t and 2 st of Health and item 27 is n r other traun	John Dieter 891 20a. Method of Disposition 20b. Place of Disp	ing Address (Street and Number or Rural Route Num O Emla Avenue Baltimore osition (Name of matory or other place) Date	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Informatist if them 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, if a Medical Examination is the rediffical at once. To Be Completed by Funeral Director	'4 □ Donation 5 □ Other (Specify) 21. Signature of Furjeral Service Licensee	of Faith 8/18/05 2. Name and Address of Facility Miller-D	
Physician	23a. Part1. Enter the disease, or emplications that caused the leath. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	6415 Belair Road Baltimon ter the mode of dying, such as cardiac or respiratory	
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Il Records, P.O. Box 6876 The law requires that the death certificate be cate has been signed by the attending physic page 2 should be detached for use as the becompleted by Physician/Medica		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
cords, P.(w requires that the been signed by should be detacted by Physical Control of the cont	Part II. Other Sgnificant conditions contributing to death but not resulting in the to		tobacco use contribute to the cause of death? Yes 2 PNo 3 Probably 4 Unknown
f Vital Records, ysician: The law requires the scentificate has been signed director, page 2 should be of the Completed by	25. Was case referred medical	per 1 ☐ Yes	opsy prior to completion of cause of death? 2 PNo 1 Yes 2 No
on of ting Phys. After this tuneral di	examiner? 1		sidence 6 Other (Specify) how injury occurred
Division or To the Hospital or Attending Ph within 24 hours after death. completely filled in by the funeral Medical Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, dear	City or T	(Street and Number or Rural Route Number, own, State)
Dir To the Hospital or within 24 hours after Within 25 hours after To the Funeral Dir completely filled in Medical Cert	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signatura and title of certifier	nvestigation, in my opinion, death occurred at the time	e, date and place, and due to the cause(s) 29d: Date signed (MoAth, Day, Year)
X	on manife and address of person who completed exuse of death (Item 239) (Type	Print) Print) 21	34
State Registrar	31. Date filed (Month, Day, Year) AUG 1 9 2005	le .	

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MARGARET DIETER 8/14/15 235

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				19a per th	5846 <u>8</u>	hifficat	e of i	Death				105	27158
П	Physicia	an	Decedent's Name (First, Middle, Last)							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Charles	areat and number!			iogu	Location of		August		05 nty of Death	7:59 P M
	Examin	er	4a. Fecility Name (If not institution, give s			,							
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	Funeral Director			^{M 2□ F} 42	Yrs.	Months	Days	Hours	Min.	(Month, Day			geria
	P.		Usual Residence of Decedent		2								<u> </u>
	arylar ehow	_	10a. State 10b. County		City, Town or Lo	e De	Cra	20					10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	he M.	Director	MD Harfor	d	пауь	10f. Zip					10g. Citizen o	of What Cou	
	a or	늅				101. 21		1070					
	ne 23	Funerai	339 Pintail Driv	2. Was Decedent Ever in	U.S. 13.	Was Dece		1078 spanic Ori	igin? (Spe	cify Yes or No- Rican, etc.)		S . A .	ican Indian,
60	riter	튑	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No						Rican, etc.)		lack, White	, etc.
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an	ld be ental ked o	To Be	Nicholes O. Ejio	2011				Jos	ephi abhi	(First, Middle, ne Ijeo ne Ih	ma Ihe	zie -	
Maryland	o,	-	19a. Informant's Name/Relationship (Type		19b. Maili	ng Address	s (Street a		-	l Route Numbe		· ·	ip Code)
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ore	ges 1 an t of Heel If itam 2 or other	l to	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b	. Place of Dispo cemetery, cre	osition (Nai matory or o	me of other plac	e)	D	ate	20c. Location	n - City or T	Town, State
Ĕ	T H B		4 Donation 5 Other (Specify)		amily	Ceme	ter	y 9	/16/	05	Nkwei	cre,	Nigeria
Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service License	• /	Ma Ma	2. Name ar arch	F/H	s of Facilit	ty L				
	0. D. ≌ ∈ ol		Jole Mo	rel	43	300 M	laba	sh A	ve,	Balti		_Md	21215 Approximate
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of Vital Records,	w require been sig should b	ed								1 🗆 Y	res 2□No	3 ☐ Pro	bably 4 Unknown
မင္ပင	law re as be 2 sho	ple								24a. Was	SV	prior to co	opsy findings available ompletion of cause of
<u> </u>	The ate h page	Completed								- perfo	rmed? 2 ☐ No	deeth? 1 🔼 Yes	2 No
/ita	sician: The law certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	ospital:			Othe		e of Death	(Check only o	ne)		
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Division	Atten r deat ctor: y the	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, st	reet, factor	y, office			28f. Location (S	Street and Nur	mber or Rui	ral Route Number,
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	To To COL	2	29b. Signature and title of certifier	00		29	c. License				29d. Date sigi		
	¥.			lan md			OCM	E		A	ugust	17, 20	005
	10		30. Name and address of person who co	npleted cause of death (I	tem 23a) (Type		Penn	Stro	et '	Raltimo	re Me	rvl an	d 21201
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sig			a		,	DOT LTHO	rici.	гутан	4 41401
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DHMH 17 Rev 1/2001

ORIGINAL

			For	State of	f Marylar	•	artment of H		d Mental Hy	giene Reg. j.R. 11 11 5	27150
			Registrar 1. Decedent's Name (First, Middle	. Last)		00	illicate of t	Jean	2. Date of De		3. Time of Death
	Physicia		Louise	,			Eddins		Month August	13, 2005 Yes	4:04 P M
	/Medic Examin		4a. Facility Name (If not institution	give street and num	nber)		4b. City, Town, or	Location of D		4c. County of D	
			2684 Lubbock	Place			Waldor			Charle	S
	Funeral Director		5. Social Security Number 261-10-8006	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bin (Month, Da Feb. 1	y, Year) 9. 7, 1913 F]	Birthplace (State or Foreign Country) Lorida
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
	Maryl -f sho	ţō	Maryland Charle	S	Wal	Ldorf					1 ☐ Yes 2 📉 No
	h the	Director	10e. Street and Number		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Lucii	10f. Zip Code		-	10g. Citizen of What	Country?
	th wit		2684 Lubbock Pl	ace			20603			U.S.A.	
	er dea	Funeral	11. Marital Status	Armed Fo		J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin' in, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	- 14. Race - A Black, W	merican Indian, hite, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marri 3 🗓 Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Giv Year or D	/8		1 ☐ Yes 2 No	Specify:		Specify: T	Thite
9	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f show he Medical Examiner must be notified at	ted	15. Decedent	's Education		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busine	ss/Industry
215	thin 7: e. an "n	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1	-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of 1)	working		
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and E	be fill	Be	17. Father's Name (First, Middle,	Last)					Name (First, Middle,	Maiden Sumame)	
Ž	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Healin and Menth Hygiene. If liam 27 is marked other than "natural", or items 23a or 28a-f show it it imm 27 is marked other than "natural" or other traumatic avant, the Modical Examiner must be notified at	<u>٢</u>	Owen Tyre 19a. Informant's Name/Relationsl	nin (Type Print)		19b Maili	ng Address (Street a		Tomlinson	ar, City or Town, Stat	a Zin Coda)
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Ē,	s 1 ar if Hea itam other	10	20a. Method of Disposition			Place of Dispo	osition (Name of matory or other place	2 3 5	Date	20c. Location - City	or Town, State
E	Page nent o int: If iry or		1 Burial 2 Cremation '4 Donation 5 Other (Si		State M	emoria.	1 Cemeter		-18-05	Lake Cit	y, FL
Baltimore, Maryland 21215-0036	permit. Pages 1 Department of H Important: If ita any injury or ot once.		21. Signature of Funeral Service	icensee B	#cc	0321 2	Querry F Guerry F P.O. Box	uneral 2409,	Home Lake City	, FL 3205	6
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Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		come of pregn wirth 2 ☐ Feta ant at time of c	al death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of Month	delivery Day Year
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Δ.	es that the igned by be detacted	by Ph	Part II. Other significant condition	ns contributing to de	eath but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contributi	e to the cause of death?
rds	- v -								1 🗆 1	Yes 2□No 3□	Probably 4 DUnknown
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of	this at di	2	1 ☐ Yes 2 🛂 No 27. Manner of Death	Hospital: 1 🔲 I		ER/Outpatier 28b. Time o		4 🗀 INUISII		dence 6 Other (S	pecify)
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	To the Hospital or Attani within 24 hours after deati To the Funaral Diractor: completely filled in by the	Medical	29a. Certifier (Check only one)	Examiner: On the ba	best of my knoasis of examination	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) and manner date and place, and d	as stated. due to the cause(s)
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	V		30. Name and address of person		e of death (Ite	m 23a) (Type,	Print)	1 1 10 = 1	1	MANINE	MD 20602
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ELISE EISENHARDT

		•	Please 1 - State Registrar		arylan	•	artment of H		nd Mental H	ygiene Reg. N2. ()	N5 2716	. n
	•		Decedent's Name (First, Middle, La	ist)					2. Date of I	Death	3. Time of D	Death
ļ !	Physicia /Medic		Elise Roxanne	Eisenhar	dt				Augus	t 1 5	2005 5:00	рм
	Examin		4a. Facility Name (If not institution, gir	e street and number)			4b. City, Town, or	Location of	Death		inty of Death	
	<u> </u>		Stella Maris	17.			Timoniu	M If Under 2	A Hrs. To D	Baltimore		
	uneral irector			Sex 7. Ag 1 □ M 2 🖾 F	51	last birthday) Yrs.	Months Days	Hours		5 1954	9. Birthplace (State or Country) MD	Foreign
land	MO III		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City	Limits
Man	ne-feh	io	MD Baltimo	re		Luth	erville				1 □ Yes :	2X No
ith the	or 28	Director	10e. Street and Number				10f. Zip Code				of What Country?	
ath w	s 23a	eral	1611 Division Av	12. Was Decedent	Europia II	6 12 1	21093		in? (Specify Ves es l	USA	Race - American Indian,	
5-UU36 72 hours after death with the Maryland	riben "naturel", or liems 23a or 28e-f ehow the Modical Examiner must be notified at	by Funeral	11. Marital Status 1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			f Yes, specify Cubai	Specify:	in? (Specify Ye <i>s</i> or I Puerto Rican, etc.)		Black, White, etc.	
Z I 3-UU30 ithin 72 hours af	ature ical E		15. Decedent's E	ducation		16a. Deced	dent's Usual Occupa	ation	of wedding	16b. Kind o	f Business/Industry	
within 7	M. n	Completed	(Specify only highest gi Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	kind of work done a DO NOT use retired,)	or working	Cattl	omant Campan	
N be s	other then		47 February News Affidation Land	<u>Z</u>		iitie	Examiner		In his way of the Addition		ement Company	
	0 6	To Be	17. Father's Name (First, Middle, Las William J.	isenhardt				Beat	rice B.	Bald		
Mar nd 2 sho	- T		19a. Informant's Name/Relationship Beatrice Eisenhar			1611	Division		ue, Luthe		wn, State, Zip Code) MD 21093	
98 1	9 10		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [1 ☐ Donation 5 ☐ Other (Special Control of		c	emetery, crer	sition (Name of natory or other place Crematory		Date 8/18/2005		on - City or Town, State sville, MD	
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			23a. Part1. Enter the disease, or con	nplications that cause	d the deat						Approximate	
	sician ledical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. ESOPHA	GEAL	CANCE	R				Interval Between Onset and De	
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; §	by the a	hysic	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□ Unknown	t time or a	eau J	Other (specify)					
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ordire equire	been sig								_ 10	Yes 2 No	3 □ Probably 4 X Un	known
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The	pag	Col							1 ☐ Yes	formed? 2 X No	death? 1 ☐ Yes 2 ☐ No	
Of VITA Physician:	is certificate director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		ED/O	Othe		of Death (Check only	- 1		
_	₽ 18	\vdash	1 ☐ Yes 2 X No 27. Manner of Death	28a. Date of Inju	ıry	28b. Time of	IL 3LI DOA	4 🗆 1901		e how injury oc	Other (Specify) HOSPI curred	CE
VISION Attending	r: After	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y rear)	Injury		? /es 2 □ N	0			
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4	1		30. Name and address of person who					гтмомт	TIM NUT 01	003		
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4	Sta Registr		DR. TARIQ MAHMO	OD 2300 D 32. Registr	ULANI rar's Signa	Y VALI		r <u>imo</u> n]	UM, MD 21	093		

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	an	Decedent's Nam		lle, Last)				_	0.7.7.1			2. Date of Month Augus		Day noo	Year	3. Time of Death
Physici /Medic		Christo							owlk			Augus				12:36 P
Examin	er	4a. Facility Name (A		-					lown, or L 1timo	Location of Ore	Death		4	4c. County	of Death	
Funeral Director		5. Social Security N 212-46-	Number	6. Sex		7. Age (In y	rs. last birthday Yrs.) If Under Months	1 Year Days	If Under 2	4 Hrs. Min.	8. Date of (Month,	Birth Day, Yea	47	9. Birth	place (State or Fore Intry) MD
≱ 1220		Usual Residence of 10a. State	f Decedent 10b. County	v		10c.	City. Town or L	ocation								10d. Inside City Lim
d e h	ţō	MD	NA			Ва	altimo	ce								1 X Yes 2 □
or 28a	lrec	10e. Street and Nu						10f. Zip	Code				10g. (Citizen of W	/hat Cou	intry?
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Deperment of Health and Mental Hygiene. Important: if item 27 ie marked other then "natural; or iteme 23e or 28a-f ehow prighty or other traumatic event, the Medical Examinat must be notilised at ance.	by Funeral Director	 Marital Status Mever Marr Widowed 		rried	2. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	ces? 2 [X No	n U.S. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc				cify Yes or Rican, etc.)	No-		k, White	ican Indian, , etc. 31ack
atura E E E	ted	/6	15. Deceder	nt's Educa	ation		16a. Dece	edent's Usual	Occupati	tion			16b.	Kind of Bu		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** FERGUSON AUGUST KONALD 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner Jamaritan HOSPITAL Baltimore NIA (100d If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. 217-52-9150 100M 20 F 5 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f ehov Examinar must be mutified at BAI TIMORE 1 Yes 2 □ No Maryland Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Bradharst Road United 2toxes 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates: Specity: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Wedical 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic even". College (1-4or 5+) Elementary/Secondary (0-12) Company able PECKNICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame), Be Shirley Mae fergusin Wayham Haywood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Namy/Relationship (Type, Print) Ferguson dhurst Road Baltmore, MD.21212 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) VA Aug 23, 2005 Owings Mills MD Garrison Formest 21. Signature of Funeral Service Licensee Balbmore, Margland & 1229 md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death ASPIRATION un know 7515 HEMOPT Physician /Medical Due to (or as a consequence of) Examiner PANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner the attending physician and ned for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 40 To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 10 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0018230 August 15, 2005 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16700D SAMARZITAN HOSPITAL KALATHIL SHASH DHARAN 31. Date filed (Month, Day, Year) AUG 1 9 2005 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

SILMORE

Betty J Galatolo 05-05546 NJM

1	, 10		1 - State Unpend Item 2	State of Maryland 3a,pt.II,27,28	/ Deparation	artment of H er. me G84 tificate of L	ealth and 1 Death	dental Hygica 5 tas	ene 2005	27164
	Di di		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medi		Betty J.	Galatolo				August	16 200	
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath
			Baltimore Washingt			Glen B			Anne Ar	
6010	Funeral Director		5. Social Security Number 6. Set 118-28-8742	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 29	(ear) 9. Bi	rthplace (State or Foreign Country)
9	/land		10a. State 10b. County	10c. City, 1	Town or Lo	cation				10d. Inside City Limits
	e Man	ctor	Maryland Anne Ar	undel		G1en	Burnie			1 ☐ Yes 2 🛣 No
	th with th	Funeral Director	10e. Street and Number 418 Brooks Court			10f. Zip Code	21060	10	g. Citizen of What C US	
5-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f ehow golical Examities must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
21	- 36	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 1	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, Retail S	luring most of worl)	king	sb. Kind of Business Departmen	·
Maryland 21	permit. Peges 1 end 2 should be filed within Department of Heelih and Mental Hygiene. Important: If item 27 ie marked other then any injury or other traumatic event, II a Manace.	To Be Co	17. Father's Name (First, Middle, Last) James Joseph	Crovo		Netari e		e (First, Middle, Mi France		C 3101 C3
	end 2 sho selth and I n 27 ie me ar traume		19a. Informant's Name/Relationship (Ty Lynore Green (D	aughter)	418	Brooks Co	urt, Gle		City or Town, State, MD 2106(
Baltimore,	Peges 1 eent of He nt: If Item ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other place ematory In			oc.Location-City o altimore,	
Balti	permit. Departm Imports any infu		21. Signature of Funeral Survice Lights			. Name and Addres	s of Facility S	tallings		Home, P.A.
8760,	Certificate be executed ding physicien and cing physicien and ise es the burial-transit	cal Examiner	23a. Fart. Enter the usease, or small shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent Due to (or as a conse	Athernice of):					Interval Between Onset and Death
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Ę.	ling F	lon	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injuryunk (Month, Day Year)	3b. Time o Injury	Work		28d. Describe how	injury occurred	unk
Division	To the Hospital or Attending Physician: The I within 24 hours eiter death. To the Funerel Director: After this cartificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 5 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str		ves 2 X No unk	28f. Location (Stre City or Town,	et and Number or R State)	tural Route Number, unk
	To the Hospital within 24 hours of To the Funeral I completely filled	edical	25a Cartifier (Check only one) 1 Gentitying Physical Examination	ner: On the best of my knowle ner: On the basis of examination and manner stated.	idge, deat and/or in	vestigation, in my op	s, date and place, inion, death occur	and due to the cau red at the time, dat	55(5) and manner a e and place, and du	s stated. e to the cause(s)
	To the total	ž	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Mon	th, Day, Year)
			I Librile H	allanin	(ME	A	ugust, 17	, 2005
		0	30. Name and address of person who co	empleted cause of death (Item 2	3а) (Туре,		Donn Ct	ob D 1		1 1 0000
	Sta	ate	31. Date filed (Month, Day, Year)	32. Signatur	θ	111 1	Penn Stre	et Balt	umore, Mai	ryland 21201
	Regist		AUG 1 9 201	35 Beach to	1	asti 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Year Month AUG. 3:00 AN **Physician** 18 FLORA В. GHANT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE MILFORD MANOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) AUG. 14 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) ^{Year)} 1928 5. Social Security Number 6. Sex Days **Funeral** Months 1 M 2 F FLDirector 135-22-9130 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show Examiner must be notified at 1 Yes 2 □ No BALTIMORE N/A MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 21215 238 3200 BARRINGTON ROAD Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 No Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: BLACK 5 1 Yes 2 No Specify. 3 X Widowed 4 ☐ Divorced Year or Dates: "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) treumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL SECURITY 4 SOCIAL WORKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If tiem 27 is marked oth ery liquy or other treumatic event ODGB. Be LILLIAN BARKLEY JULIUS BOWDEN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7445 PRINCE GEORGE ROAD, BALTO., MD 21208 WENDY DUKES/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST V.C. 08-26-05 OWINGS MILLS, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signa ure of Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Camiothrandotic Friysician event disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner altheroscleratio cardiovasenlar disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit CORD and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 23e. Did toba use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ s been signed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 □,N6 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 41 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 No Certification: To After th 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Rekajupahreno. Dan 57465 5/18/05. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Mainst, suite 200, Reisterstown, MD-21136.

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

31. Date filed (Month, Day, Year) AUG 1 9 2005 DHMH 17 Rev 1/2001

S. Kajapakse, M.D

ORIGINAL

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32. Registrar's Signature

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	1		1- State of Maryland / Department of Health and Merital Hygierie Certificate of Death Reg. No. 205-27/	60
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De	ath
	Physicia /Medic	ai .	Cathorine 21100 400 TASZ August 10, 2005 14=32	M
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	Director		213-28-6537 73 Yrs. Apr. 19, 1932 Maryland	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City L	imits
	Maryl -f sho	ţ	Maryland Harford Abingdon	No
	or 28e	Directo	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	within 72 hours after death with the Maryland ane. than "natural", or itams 23e or 28e-f show than "notical Examiner must be notified at	rai	4029 Abinrox Drive 21009 USA 11 Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,	
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936	rai, o	p.	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 ☒ No Specify: Specify: White	
21215-0036	72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
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ylaı	ould b Menta	2	Vincent Leo Simmons Maria (nmn) Ruckelhaus	
Maryland	d 2 sh thand thand 7 is m traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred F. Gontasz / Husband 4029 Abinrox Drive, Abingdon, Maryland	
	f Heali f Heali itam 2 other		20a. Method of Disposition 20b. Place of Disposition (Name of camptany or other place) 20c. Location - City or Town, State	
E	Pages nent of int: If it iry or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 8-12-05 Towson, Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic evant, Ite Medical once.		21. Signature of Funeral Service Licensee Wave T Rose 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokeshury Road, Abingdon, Maryland 2100	
	₫ D E 6 0		1517 CONCESSORY TEXAS TRAINING TEXAS 2200	
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	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
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	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
	10		31. Date filed (Mooth, Day, death) \$2336 40 VK VD 1, MONGON MD 2 (093)	
	Sta Regist		11:11:3 / (11) Algarithm a 15 and 15	

Amend item #11 per wife G861 11/21/06 amh Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FORT WASHIN
If Under 1 Year If Under 24 Hrs. PRIN Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days Months Usual Residence of Decedent Yrs. Director GUATEMALA Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic evant, the Medical Examiner must be notified at 1 Yes 2 No To Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 13727 Itams 23a VITED 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 Yes 2 No Specify: GUATEMALAN Specify: WHITE 4 Divorced "netural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i LARA GOMEZ/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State ANATOMY GIFTS REG 8 ' 4 Donation 5 ☐ Other (Specify) 21. Signatur / Fur ral Ser 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23á. Part1. Enter the disease or complishock, or heart failure. List only on Approximate Interval Between Onset and Beath plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner burial-transit or Attanding Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 🗌 Yes 22 No Certification: To 1 Inpatient 2 ER/Outpatient 4 Nursing Home Residence 6 □Other (Specify) 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred : After 1 1 Natural 2 ☐ Accident 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No after death Diractor: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To tha Funaral L 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mgnth, Day, Year) of person who completed cause of death (Item 23a) (Type, Print), w) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 9 2005

		State of Maryland / Department of Health and N 1- State Registrar Certificate of Death	_	giene	5 27168
Physicia		Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
Physicia /Medic		William Ennis Gunther, Sr.	August		
Examine	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of	
Funeral		Stella Maris Timonium 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt	th 9	timore Birthplace (State or Foreign
Director		216-01-6927 15x 2□ F 90 Yrs. Months Days Hours Min.	Sept. Da	8,1914	Maryland
bra *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryli f sho	jo	Maryland Baltimore Timonium			1 ☐ Yes 2 ☐ No
r 28e	lrect	10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	
th with	aiD	2300 Dulaney Valley Road, Unit #384 21093	-	United	States
r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Amged Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Race -	American Indian, White, etc.
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show its Madical Exertinal remains a notilified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates:		Specify:	White
2 hours	ted t	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busin	
215 Pan 72 Media	ple	(Specify only highest grade completed) Elementary/Secopodary (0-12) College (1-4or 5+) Financial Advisor	ing		,
21. De tr. In.	Completed	Tinancial navisal		Self Em	ployed
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours all ppartment of Health and Mental Hygiene. portant: if item 27 is marked other than "natural, or yinjury or other treumatic event, the Medical Energica.	Be	17. Father's Name (First, Middle, Last) Albert Funther 18. Mother's Name Elizabe	eth 0'Co	Maiden Sumame)	
aryla should ind Men s marke umatic	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	A Pouto Numbo	or City or Town Sta	to Zin Code)
, Ma and 2 s ealth ar n 27 is		Mr. Jeffrey H. Gunther, Son 14409 Silver Burch Cour			
A A S 1 a S		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - Cit	
imor Pages ment of ant: if th		`4 Donation 5 Other (Specify) Dulaney Valley Memorial Gdns. 8/1	6/05	Cimonium,	Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: if them 27 is marked other than "natural", or itams 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.		21. Signature of Fune 1 Septice (Jensee MO1113 200 E. Padonia Rd.,			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)			Onset and Death
/Medical Examiner		Due to (or as a consequence of):			
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c			
8760, (2) sale be executed by stician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
\$8760, \$\times\$ icate be executed physician and s the burial-transit	dical	d			
HER AUGUST 13, 2 Records, P.O. Box 6 The law requires that the death certificate has been signed by the attendings page 2 should be detached for use as	/Me	IF FEMALE: 23b. Was decodent program: 23c. If yes, outcome of pregnancy			
Bo Boath atten	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		23d. Date of Month	Day Year
P.O.	hysi	9 ☐ Unknown 9 ☐ Unknown			
rds, P.C	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
AL Cord Cord w requir baan si	ted	Vascular Dementia	1 🗆 Y	es 280 No 3	Probably 4 Unknown
VITAL RECORDS, VITAL RECORDS, siclen: The taw requires t certificate has been signerector, page 2 should be to	Completed		24a. Was a autop	an 24b. Wer	e autopsy findings available to completion of cause of
GUNTHER I VITAL Re la ysiclen: The la sis certificate has director, page 2			perfor	med? deat 2⊠No 1□	h? Yes 2.☑No
VIt VIt sicler sicler irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Hor			
M Of I of g Physer this seral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2		ence 6 Other (.	Specify)
isior isior ttendin death. ctor: Aft	atlo	2 Accident investigation M 1 Yes 2 No			
WILLIAM Division of in or attending Fatter death. Director: After I in by the funeral in by the funera	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	itreet and Number o	r Rural Route Number,
Despital of hours all unerel D		29a. Certifier 1 X Certifying Physician: To the best of my knowledge death occurred at the time, date and place a			
24 H	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the c ad at the time, d	ause(s) and manne date and place, and	r as stated. due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier 29c. License number	2	29d Date signed (M	onth, Day, Year)
		Friestine Wight, MD DS2740		Hugust	15 m 2005
13		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		wn 07005	
Curt		ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIM 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ONIUM,	MD 21093	
Stat Registra	-	MIG 1 9 2005 Broke & Spell			

			Please	State of Marylan				-	_	
		4	For State	State of Marylani		rtificate of			2005	27169
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
	Physicia		Kenneth 6	noeller				Month	Day Yeer 16-2005	04: 18 AM
)	/Medic Examin	- 0	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Deatl	h	4c. County of Deet	h
	2	Ħ	Good Samaritan			Baltin	ore	O Data of Bird	D. Rie	Talana (Cinta as Fassian
	Funeral		5. Social Security Number 6. Se	3M 2□ F	ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da)	y, Year) 5. 5/11 1020 Ral+	nplace (Stete or Foreign untry) O., Maryland
	Director		214 26 0705 Usual Residence of Decedent	X 76				May 20,	1929 Daic	
	how		10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f •	Directo	Maryland Baltimor	e M	Middle				10g. Citizen of What Co	Λ
	with the		10e. Street and Number	lr Tono		10f. Zip Code 212	20		USA	•
	be filed within 72 hours after death with the Maryland all Hyglene. de thylone death and "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at	Funeral	16 W. Kingston Pa	12. Was Decedent Ever in U.	.S. 13.	Was Decedent of H		pecify Yes or No		rican Indian,
٥	or iten	Fun	1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 X No		If Yes, specify Cub 1 ☐ Yes 2 ☒ No		(o Hican, etc.)	Black, White	White
21215-0036	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:						
2	"natu	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	ident's Usual Occup is kind of work done OO NOT use retire	during most of wo	rking	16b. Kind of Business/	Industry
7	filed within Hygiene. other then "	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		Patern M	_		Seal Manuf	acturing
2	illed w Hygier other th	BeC	17. Father's Name (First, Middle, Last)		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			me (First, Middle,	Maiden Sumame)	
<u>lar</u>	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, Ibe M	To B	Frederick	Goelller			Franci			
Maryland	2 sho and I ie me	i i	19a. Informant's Name/Relationship (7	•					er, City or Town, State, 2 More, Maryl	
_	permit. Pages 1 and 2 should by Department of Health and Menis Important: If item 27 is marked any injury or other traumatic a <u>ance</u> .	1 8	Dorothy Goeller 20a. Method of Disposition	(wife)	Place of Disp	osition (Name of		Date	20c. Location - City or	
altimore,	Pages nent of H int: If its ury or of		1 ☐ Burial 2 🎇 Cremation 3 🗆	Removal from State	cemetery, cre	matory or other pla		2/2005	Baltimore,	
	artme ortani injury		*4 Donation 5 ☐ Other (Specify 21. Signature of Funer (Service Licent						ki Funeral	
B	Depar Impo		1-13		1	407 old E	Castern A	venue Es	sex Marylar	d 21221
			23a. Part 1. Enter the disease, or com- speck or heart failure. List only	lications that caused the deat	h. Do not en	nter the mode of dy	ng, such as cardia	c or respiratory ai	rrest,	Approximate Interval Between Onset and Death
>	Physician		Immediate Cause (Final disease or condition		hosit					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	quence of):					
	LXdiiiiici	-	Sequentially list conditions.	b. Due to (or as a conseq	juence of):					
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Ć.	e be executed sician and e burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a conseq	(uence of):					
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Bo)	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of d	al death 3	☐Ectopic pregnant ☐ Other (specify) _	су		23d. Date of de Month	Day Year
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Records,	w require been sig should b		Adrb Ren	al failure,				1 🗆 '	Yes 2 ☐ No 3 ☐ Pi	obably 4 Unknown
000	e law re has bed je 2 sho	Completed	1					24a. Was	an 24b. Were as	utopsy findings available completion of cause of
æ	The ate h	Con							ormed? death? 2□No 1□Yes	2 🗔 No
Vita	ding Physician: The I h. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:		- 0	han	ath (Check only o	-	
of	Phys r this ral dii	.: To	1 Yes 2 No	28a. Date of Injury	ER/Outpatie 28b. Time	of 28c. Inju	4 Nursing	7	dence 6 Other (Spe how injury occurred	city)
on	Attanding or death.	atior	1 Datural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		ork?]Yes 2∐No			
Division of Vital	i or Attand after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special		treet, factory, office		28f. Location (City or To	Street and Number or R. wn, State)	ural Route Number,
	To the Hospital or Attanwithin 24 hours after death To the Funaral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of my knoniner: On the basis of examina	owledge, dea	ath occurred at the	time, date and place	e, and due to the	cause(s) and manner as	s stated.
	To the Ho within 24 To the Fu completel	ledical	one)	and manner stated.	word and of t				29d. Date signed (Mont	
	To To	Σ	29b. Signature and title of certifier	11 A		Zac. Licer	Se number	0	A Q (A	Jay, 1641)
	M		30. Name and address of person the	completed cause of death (Ite	m 23a) /Tvn	a Print)	0,22		00-10-	07
6.0	l '		Vilau R. Heads			ton Hor	mbal. 1	Saltime	one, MD	21239
		ate	31. Date filed (Month, Day, Yeer)	32. Registrar's Sign						
	Regist	rar	AUG 1 9 2	2005	Age	Acard .				

			1 - For State Registrar	State of Maryl	-	ertificate		Mental Hy	giene Reg. R e	A A	27170
	Physici /Medic		1. Decedent's Name (First, Middle, Last) CHARLES		H	122		2. Date of D Month Aひらいら	Da		3. Time of Death
	Examin Funeral Director		4a. Facility Name (If not institution, give : W. CONWAY 5. Social Security Number 216 - 80 - 1352	ST. APT.	F605 yrs. last birthday o Yrs.	BA If Under 1 Y	m, or Location of Dea LTIMOR ear If Under 24 Hr ays Hours Mir	s. 8. Date of B	4c.	County of Death	place (State or Foreign
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or I	ocation					10d. Inside City Limits
	he Man 8a-fsh offied	ector	MARYLAND NIA		BAL						1 ✓ Yes 2 □ No
	th with t	ai Dir	10e. Street and Number W. CONWAY	ST. APT	4605	10f. Zip Co			-	izen of What Cou	intry?
336	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	in U.S. 13	. Was Decedent If Yes, specify	of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or N rto Rican, etc.)			
2	c * m	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Giv life.	edent's Usual O te kind of work o DO NOT use r	one during most of watired)	orking		ind of Business/Ir	CUP CO.
ੁ	should be filed within to Mental Hygiene. marked other than matic event, the Manatic event events ev	Be	12TH GRADE 17. Father's Name (First, Middle, Last)			0310	18. Mother's N	ame (First, Middl	e, Maiden	Sumame)	
aryla	ges 1 and 2 should if of Health and Men if item 27 is marke or other traumatic	ပ	19a. Informant's Name/Relationship (Ty		19b. Mai	ling Address (S	ELLEA reet and Number or F			RIGHT/ or Town, State, Zip	
	1 and 2 Health a em 27 i		ELLEN HILL (III		4200 b. Place of Disp		TER ST,	BALTIN		EMD cocation - City or To	
timore,	Pages 1 nenf of H ant: ff ite ury or oth		1 Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	lamoval from State	cemetery, cr	ematory or othe	place)				MARYLAND
Balt	permit. Page Department Important: fi any injury o		21. Signature of Funeral Service License	h. Wille	iams 5	22. Name and A OSEPH	H. BROW FULTON	ON JR.	FUN	IERAL H	HOME 21917
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	mmune	nter the mode o	dying, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death Vedus
	Ilicate be executed g physician and as the buriat-transif	al Examiner	Sequentially list conditions, and be cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con							
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate i within 24 hours after death. within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the to	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	.3c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	☐Ectopic pregr ☐ Other (speci				23d. Date of deliving Month	ery Day Year
rds, P	quires that in signed build be det		Part II. Other significant conditions con	ntributing to death but not	resulting in the	underlying caus	a given in Part I.		tobacco i		the cause of death?
Division of Vital Records,	: The law re cate has bee page 2 sho	Completed							s an opsy formed?	prior to co death?	opsy findings available impletion of cause of
	/sician s certifii director	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpati	ent 3 DOA	O#	eath (Check only		6 ☐ Other (Special	6.1
ion of	To the Hospital or Atlending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time	of 28c.	Injury at Work? 1 Yes 2 No	28d. Describe			ny)
Divis	tal or Affers after de al Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - i building, etc. (Sp	At home, farm, s pecify)	street, factory, of	fice	28f. Location City or To	(Street an own, State	nd Number or Rur)	al Route Number,
	e Hospi 24 hour a Funer etely fill	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, dea mination and/or	ath occurred at t investigation, in	ne time, date and place my opinion, death occ	ce, and due to the curred at the time	cause(s) , date and	and manner as s d place, and due t	stated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		····		cense number			te signed (Month,	
	n		30. Name and address of person who co	empleted cause of death	(Item 23a) (Type	D24170 838 N Eutaw St Baltin				IST 18, 2	00 S
	5		E. TSUMD Rid	ney Hospice	838 I	V Euta	wst	Baltin	M	MDZ	1201
	State 31. Date filed (Month, Day, Year) Registrar AUG 1 9 2005			15	12. Begistrar's Signature						

Charles

Private Priv	1 - For State Regis	1	1- State of Maryland / Department of State of Maryland / Department of Certificate of Certificat		Hygiene	5 27171					
Anno Arruade I. Medical Center Anno Arruade I. Medical Center Social Security Number 2. Social Secu	ician Holo	Physician	n Holono V Hughanda	Mont	of Death th Day Y	3. Time of Death					
Anne Arundol Medical Center S. Social Security Number	ulcal .		31								
Second Security Number 6. Sex 20.4 - 16 - 9.864 Image Name N		LAdimine									
Director 204-16-9864 106. Closely 106. City, Town or Location 106. Indice City L 108. Street and Number 106. City Town or Location 107. City Code 1187 vs 27 1188 vs 27 1188 vs 27 1188 vs 27 1188 vs 27 1188 vs 27 1188 vs 27 1188 vs 27 1188 vs 27 1188 vs 28 2 2 : 12	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye									
100 100			204–16–9864 79 Yrs.	ys Hours Min. 04/	05/1926 P						
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The state of the	10e. Stree	28e- nonth	10e. Street and Number	de .	10g Citizen of Wh	at Country?					
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Surial 2 Cramation 3 Removal from State Companies Compan		and N		eet and Number or Rural Route f	Number, City or Town, St	ate, Zip Code)					
Surial 2 Cramation 3 Removal from State Companies Compan		n 27			MD 21114						
23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Control of Part II. The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Control of Part II. The conditions of the analysis of the conditions			20a. Method of Disposition 20b. Place of Disposition (Name of company) company of the company o	place)	20c. Location - Ci	ty or Town, State					
23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Control of Part II. The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Control of Part II. The conditions of the analysis of the conditions		tent: jury	Cemetery	00/23/20	05 Brentwood	i, MD					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and shock or heart failure. List only one cause on sich piec. Immediate Cause (Final state of the cause) Immediate Cause (Final state of the ca	21. Signat	Impou eny ir once.									
Immediate Cause (Final diseases or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death)	23a. Part		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of			Approximate					
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The state of the s	that initiate resulting in	al-trag	that initiated events c								
Specific Specific	cai	/siciar e buri cal E	a d								
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24a. Was all open interest and	IF FEMAL 23b. Was	r use	IF FEMALE: 23c. If yes, outcome of pregnancy 10 Live birth 2 Festal death 3 Federic pregnancy	ancv							
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24a. Was all open interest and	Δ /	signe d be o	ā // · · · · · · ·	given in Part I. 236.							
24a. Was all open interest and	ete	should									
25. Was case referred to medical examiner? 1	du	ge 2	e		autopsy pric	or to completion of cause of					
inpatient 2 Ervoutpatient 3 DOA 4 I Nursing Home 5 I Residence 6 I Other (Specify)	0	10 T	O		Yes 2DNo 1□						
27. Manner of Death 1	m examin	s cert direct	m examiner?	Other		(Specify)					
To the Calural S pending (Month, St.) 16th (Month) 1 Yes 2 No		heral									
	ation 2 A	or: Af he fur	2 Accident investigation M								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	3 □ Si 4 □ H	irecte orby t rtific	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, offi building, etc. (Specify)	ce 28f. Loca City	tion (Street and Number or Town, State)	or Rural Route Number,					
29a. Certifier 19 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated	9 292 Corti	erel C									
The state of the s	(Chec	he Fun bletely bletely edica	(Chark only 2 Madical Evaminary On the bosis of evamination and (as investigation and date of the state of th								
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		To t	≥ 29b. Signature and title of certifier 29c. Lic	ense number	29d. Date signed (/	Month, Day, Year)					
1 / Mellin my 024804 8-18-05			1 / yellen my	24804	8-18-	05					
30. Name and a dress of p rson who completed cause of death (Item 23a) (Type, Print) Robert T Peterson MD AAMC Annache Md 21401	D		30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Robert T Peterson with AA	Mc Anne	note Md	21401					
State Registrar State Registrar AUC 1 9 2005 Reduced Examiner and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 8-18-65 30. Name and a dress of p rson who completed cause of death (Item 23a) (Type, Print) A MC Annagelis Mc 21401 31. Date filed (Month, Day, Year) 32 Registrar's Signature AUC 1 9 2005 Auc 1 4 MC Annagelis Mc 21401 31. Date filed (Month, Day, Year) 32 Registrar's Signature AUC 1 9 2005 Auc 1 4 MC Annagelis Mc 21401 32. Registrar AUC 1 9 2005 Auc 1 4 MC Annagelis Mc 21401 33. Registrar AUC 1 9 2005 Auc 1 4 MC Annagelis Mc 21401 34. Registrar AUC 1 9 2005 Auc 1 4 MC Annagelis Mc 21401 35. Registrar AUC 1 9 2005 Auc 1 4 MC Annagelis Mc 21401 36. Registrar Auc 1 4 MC Annagelis Mc 21401 37. Registrar AUC 1 9 2005 Auc 1 4 MC Annagelis Mc 21401 38. Registrar AUC 1 9 2005 Auc 1 4 MC Annagelis Mc 21401 39. Registrar Auc 1 4 MC Annagelis Mc 21401 31. Registrar Auc 1 4 MC Annagelis Mc 21401 31. Registrar Auc 1 4 MC Annagelis Mc 21401 32. Registrar Auc 1 4 MC Annagelis Mc 21401 33. Registrar Auc 1 4 MC Annagelis Mc 21401 34. Registrar Auc 1 4 MC Annagelis Mc 21401 35. Registrar Auc 1 4 MC Annagelis Mc 21401 36. Registrar Auc 1 4 MC Annagelis Mc 21401 37. Registrar Auc 1 4 MC Annagelis Mc 21401 38. Registrar Auc 1 4 MC Annagelis Mc 21401 39. Registrar Auc 1 4 MC Annagelis Mc 21401 31. Registrar Auc 1 4 MC Annagelis Mc 21401 31. Registrar Auc 1 4 MC Annagelis Mc 21401 32. Registrar Annagelis Mc 21401 33. Registrar Annagelis Mc 21401 34. Registrar Annagelis Mc 21401 35. Registrar Annagelis Mc 21401 36. Registrar Annagelis Mc 21401 37. Registrar Annagelis Mc 21401 38. Registrar Annagelis Mc 21401 39. Registrar Annagelis Mc	State	Otate	31. Date filed (Month, Day, Year) ALIG 1 9 2115								

			1 - For State Registrer	State of M	aryland / Depa <i>Ce</i>	artment of H		and Mental Hy	/giene	27172
	Physic		1. Decedent's Name (First, Middle, La	HAWKIN	15			2. Date of D Month	eath Day Yea	
	/Medi Examir		4a. Facility Name (If not institution, given		v	4b. City, Town, or	Location o	AUGUS*	7 15 200 4c. County of De	
	Funeral				17AL ge (In yrs. last birthday)	BALT// If Under 1 Year	nof &	MARTIA 24 Hrs. 8. Date of Bi		OLE CITY inthplace (State or Foreign
	Director		218-64-0445 Usual Residence of Decedent	1□M 25 F	51 Yrs.	Months Days	Hours	Min. 0 (Month, D		MD
	yland how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Ma Sa-f s	ctor	MD NA	4	Baltimo	re				1y Yes 2 No
	vith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	sath v	era	3614 Ravenwood	Ave	Eventia II C		21213		U.S.A	
"	r Item	Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Forces?	No No	If Yes, specify Cuba	ispanic Orig in, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	0- 14. Hace - Ar Black, Wi	nencan Indian, nite, etc.
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at	Þ	3 ☐ Widowed 4X Divorced	If Yes, Give Year or Dates:		1 ☐ Yes XXNo	Specify:		Specify:	Black
15	in 72	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	turina most	of working	16b. Kind of Busines	s/Industry
212	iene.	шо	Elementary/Secondary (0-12) 8th grade	College (1-4or !	5+)	Disabled	•		Disab	led
b	12 should be filed within "h and Mental Hygiene." 7 Is marked other than "traumatic event, It a Me.	Be C	17. Father's Name (First, Middle, Last			DIBUBICO		r's Name (First, Middle		150
<u>Ja</u>	Menta	_	Johnny Robinson	1			Corne	elia E. R	eams	
Maryland	2 shot and less made raum		19a. Informant's Name/Relationship (er, City or Town, State	
	1 and 2 Health tem 27 l	1 8	Alfonzo Hawkins 20a. Method of Disposition	s-Son	3614 20b. Place of Dispo		od A	ve, Balt	imore, Mo	
Baltimore,	Pages nent of F ant; If ite ary or of		1 🕅 Burial 2 ☐ Cremation 3 ☐		cemetery, crei	natory or other place	. !		20c. Location - City of	r Town, State
Ē	permit. Page Department of Important; If any injury or once.	- 1	* 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	•	22	. Name and Address	s of Facility	171	Randalls	town, Md
B	permit. Departr Imports any inju		> Tala V	Mark	M a	arch F/H	I Wes	t ve, Balt	imore, Md	21215
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not ent	er the mode of dying	g, such as c	cardiac or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Δ	750 0	PILURE				Onset and Death
	/Medical Examiner		resulting in death)	u	a consequence of):	1-100 00				
	_xanimic:	er	Sequentially list conditions, if any, leading to immediate	b. SEP	a consequence of):					
7	uted 1 Insit	mine	Cause (Disease or injury	Due to (or as	a consequence or.					
ó	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
8760,	cate be executed physician and the burial-transit	dicai		_ d						
Ψ		/Med	IF FEMALE:	20. 14						
Вох	death certifi e attending I id for use as	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of de Month	elivery Day Year
	0 00	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or death 5	Other (specify)				,
S, D	The law requires that the tee has been signed by the sage 2 should be detache	by Pl	Part II. Other significant conditions	ontributing to death b	ut not resulting in the ur	nderlying cause give	n in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ğ	v require been sig should b	led t	SARCOIDOSIS					10	Yes 2.00 3 □ F	Probably 4 Unknown
Record	e law n has be je 2 sh	Completed						24a. Was		utopsy findings available completion of cause of
		Con						perfo	ormed? death?	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Otho	-	of Death Check only		
of		1: To	1 Yes 2 No	1 Depatie		t 3 DOA Othe	4 LINUIS		dence 6 Other (Sp.	ecify)
on	Attending I r death. ector: After by the funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	Work	? ′es 2.∐N		now injury occurred	
Division		ertification:	3 Suicide 6 Could not b	28e. Place of Inju	ury - At home, farm, stre	eet, factory, office		28f. Location (Street and Number or F	Rural Route Number,
Ö	Ital or A rrs after ral Directed In by	O						City or To		
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysician: To the best on niner: On the basis of and manner sta	examination and/or inv	occurred at the time restigation, in my op	e, date and inion, death	place, and due to the occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	-/		29c. License	number		29d. Date signed (Mon	th, Day, Year)
		,	Herbert A. Tre	colnor- Ma	<i>(</i>).	019	307		AUGUST 15	2005
	, 8		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, I	Print)	(1)	144	And is	
	Sta	to.	HELBEFT A. FRIEDMAS 31. Date filed (Month, Day, Year)	32. Registra	ON LOCHE	MUEN BLO	10, B	BLTIMERE	DIO 210	139.
	Registr		AUG 1 9	2005	w. H. A	anlis			29d. Date signed (Mon AUCUST 15 MO 213	

			For State Registrar	State of Maryland	•	ent of Health and late of Death	Mental Hygiene	2005	27173
	Physici /Medio			TTON	4.0	To a decide of Door		y Year 7 2005	3. Time of Death
	Examir Funeral Director	ner	4e. Fecility Name (If not institution, give SOHNS HOPK 5. Social Security Number 6. Sec.	INS BAYVIE	$=\omega$	BALTIM Jer 1 Year If Under 24 Hrs. Days Hours Min.	NORE		place (State or Foreign
	death with the Maryland me 23a or 28e-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County BACT N	10c. City	, Town or Location BALTI	MORE		1	0d. Inside City Limits 1 ☐ Yes 2 No
	ath with the	ral Director	10e. Street and Number 7501 Park J	Drive.		21234		tizen of What Cour	
5-0036	thin 72 hours after death with the Marylar 8. In "natural", or Iteme 23a or 28e-f ehow Magical Expositive mast be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerl	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify:	
0-61212	E 6 5 8	Completed	15. Decedent's Ed. (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5+)	16a. Decedent's U. (Give kind of life. DO NOT	work done during most of wo use retired)		A home	dustry
yland	ould be filed Mental Hygi arked other	To Be C	17. Father's Name (First, Middle, Last)	Korte		Erne		epperc	d
ore, mar	ges 1 and 2 shi it of Health and If Item 27 Is m or other traum		19a. Informant's Name/Relationship (7) 20a. Method of Disposition 1 W Burial 2 Cremation 3 F	20b. P	19b. Mailing Addre	ass (Street and Number or Ri A Har for A Vame of or other place)	UI QA	or fowh, State, Zip NORE N ocation - City or To	10 21234 own, State
Baltimore,	permit. Pages Department of Important: If It any Injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	arl	EVAL	and Address of Facility	22-05 MU ALTIMORE WHOEL XX	CRUILLE MD 21 COHARE	MD 234. 02D 20
	Physician /Medical Examiner		23a. Pan 1. Enter the dis rise, in composition of the composition of t	ir ation, that cused to e death ye cause on each line a. Due to (or as a consequence)	bium D				Approximate Interval Between Onset and Death
760, 7	icate be executed physicien and sthe burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence)					
O. Box 68	death certif e attending id for use a	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 INNo 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	I death 3 Ectopic			23d. Date of delive Month	ery Day Year
1	juires that n signed b		Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlyin	g cause given in Part I.			he cause of death? pably 4 Unknown
Vital Records,	The law requires that the cate has been signed by the page 2 should be detached.	Completed					24a. Was an autopsy performed?	death?	opsy findings avaitable mpletion of cause of
VIE V	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			ath (Check only one)		
n of	Phys this ral di	on: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	28c. Injury at Work?	Home 5 Residence 28d. Describe how inju		(y)
Division of	or Atten ifter deat Diractor: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	M ome, farm, street, fac y)	1 ☐ Yes 2 ☐ No tory, office	28f. Location (Street a City or Town, State	nd Number or Rura (e)	al Route Number,
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurr tion and/or investigat	ed at the time, date and plac ion, in my opinion, death occ	e, and due to the cause(surred at the time, date an	s) and manner as s ad place, and due to	stated. the cause(s)
V	within To the	Me	29b. Signature and title of certifier	alel		29c. License number		ate signed (Month.	
,	*		30. Name and address of person who o	ompleted cause of death (Iten	n 23a) (Type, Print)	33709 AVENUE,	8	117/2	005
	17		KAPIL PARAKH * 31. Date filed (Month, Day, Year)	7940 EAS	TERN	AVENUE,	BALTIMOR	ie mi	0 21208
	St Regist	ate		2005	H. Com	de s			

DEME 17 Flev 1/2001

			For State Registrar	State of Maryland	-	artment of Hertificate of L			giene 005	27174
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Las Bessie May Howard As Facility Name (If not institution, give			4b. City, Town, or		2. Date of Dea Month August	Day Year 16, 2005	12:49P. M
	Funeral Director	G!	Greater Baltimore 5. Social Security Number 6. Sec 220-12-5476				ISON If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) Sept. 2	Baltimor b, Year) 9. B 1,1912 Bal	e County inthplace (State or Foreign country) timore, MD.
	the Maryland 28e-f show rotified at	ctor	10a. State 10b. County Maryland Baltimor		, Town or Lo					10d. Inside City Limits 1 ☐ Yes ②∑XNo
	th with the 23a or 28	Funeral Director	10e. Street and Number 316 Starlight Pla	ce		10f. Zip Code	.093		10g. Citizen of What C United St	•
5-0036	after dea or items	þ	11. Marital Status 1 Never Married 2 Married 3 Modowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☒ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
215-0	c * m	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of worki	ng	16b. Kind of Busines	s/Industry
nd 2121	2 should be filed within 72 h and Mental Hygiene. is marked other then "natu aumatic event, the Medical	Be Com	06 17. Father's Name (First, Middle, Last)	N/A			18. Mother's Name			Home
Maryland	should be and Mental is marked o	L _O	Frederick Smith 19a. Informant's Name/Relationship (7)	ype, Print)	19b. Maili		Bessie H		r, City or Town, State,	Zip Code)
	es 1 and of Health fitem 27 r other tr		Drs. Barbara Hyde 20a. Method of Disposition 1 Dispuise 2 Cremation 3 Disposition	20b. P		osley Ave.		ate	, Maryland 20c. Location - City o	
Baltimore,	perrit. Pag Dep rtment Important: I any injury o		'4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License	Dul	aney V	Jalley Men 2. Name and Address eaceful Al	n.Gard.	•	Timonium, ral&Cremat	Maryland ion Center 21093
	Physician /Medical Examiner		23a. Part I English to disease or company to the list only of the list only only only only only only only only	Due to (or as a consequ	Do not ent	325 YOLK IN er the mode of dying	(Odd Time, such as cardiac c	NOTITUIN, or respiratory ar	Maryland rest,	Approximate Interval Between Onset and Death
8760, 🌾		Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. First Indestyn. Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence.	uence of):		nja	دانو	<u></u>	Ixan
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
Ω.,	quires that n signed b uld be deta		Part II. Other significant conditions ∞	ontributing to death but not resu	ulting in the u	nderlying cause give	n in Part I.	23e. Did to	obacco use continute res 2 MNo 3 🗆 F	to the cause of death? Probably 4Unknown
Vital Records,	The law requinate has been spage 2 should	Completed						24a. Was a autop perfor	sy prior to	
f Vita	ysician: The is certificate hadinector, page	To Be	25. Was case re rred to edical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 💆	ER/Outpatier	Otho	26. Place of Death		ne) ence 6 Other (Sp	ecity)
Division of	Attending Physician: r death. ector: After this certifica by the funeral director, p		27. Manny of Death 1 Natural 5 Pending investigation		28b. Time o Injury	Work'			ow injury occurred	
Divis	in Signal	Certification:	3 Suicide 6 Could not ed determined	building, etc. (Specify)	,		City or Tow		
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exam	ysician: To the best of my know liner: On the basis of examinat and manner stated.	wledge, deat ion and/or in	vestigation, in my opi	nion, death occurre	ed at the time, o	date and place, and du	e to the cause(s)
	To wit	-	29b. Signafure and title of certifier	T. Gleno	~ m	29c. License	2-32	5	29d. Date signed (Mon	6 05
	5		30. Name and address of person who of	Gilmore, 1	h.D.	Print) 2221-	-3 Tulla	more	Rd. Luth	en7/e, MD.
	Sta Registr		31. Date filed (Month, Day, Year)	32. Register's Signat	ture #	Goods				

			For State	State of Maryland	Department // Department // // // // // // // // // // // // //			2005	27175
	235		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate	or Death	2. Date of Death	. N6 U U U	3. Time of Death
Ž.	Physicia	ın	Town M	Hannech	in		AUQ 1	18 2005	4:33PM
	/Medica	_	ta. Facility Name (If not institution, give str	reet and number)		own, or Location of Deal	h	4c. County of Death	
	+ 1			Ter 7. Age (In yrs. las		Year If Under 24 Hrs	8. Date of Birth		place (State or Foreign
12	Funeral Director		5. Social Security Number 6. Sex	4 2XF 72	Yrs. Months	Days Hours Min	8. Date of Birth (Month, Day, Y	(ear) Could	INOIS
			Usual Residence of Decedent	10c City 3	Town or Location				10d. Inside City Limits
a Via	•hov	0	10a. State 10b. County		BALTIM	20 =			1 ☐ Yes 2 XNo
đ A	28a-	rect	10e. Street and Number	ORE	10f. Zip		10g	g. Citizen of What Cou	ntry?
či Ši	23a ol	al Di	2825 Cub Hil	1 Rd.		21234		USA	
dea	tems	uner	**	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Deced If Yes, spec	ent of Hispanic Origin? (fy Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White,	
1215-0036 within 72 hours after death with the Maryland	o.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	1 ☐ Yes 2	No Specify:		Specify: W	hite.
5-0(nature licul E	Completed	15. Decedent's Educa (Specify only highest grade		16a. Decedent's Usua (Give kind of wor	k done during most of wo	nrking 16	6b. Kind of Business/In	ndustry
12 jag	hen.	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	GCOOME	/ 41	ager	Kennel	
d d	Hygie other	e Co	17. Father's Name (First, Middle, Last)		Groome		me (First, Middle, Ma	viden Sumame)	
'lan	Aental rked tlc ev	To Be	Inknown			UNKN			
Maryland 21215-0036	and the market		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Address	(Street and Number or F	ural Route Number, (City or Town, State, Zi	D 2 17 2(1
	Health am 27 ther t		20a. Method of Disposition	20b. Plac	ce of Disposition (Nan	De of	Date 20	Oc. Location - City or T	own, State
mor	ent of nt: if it ry or o		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	and the same of th	SFUNERAL	CHAPPL- 8-	1905 F	Forest Hi	11, MD.
Baltimore,			21. Signature of Funeral Service kicenser			d Address of Facility	BALTI MORE	E, MD 21	234.
ш 3	105 g		23a Part 1 Enter the disease or complic	ations that caused the death.	Do not enter the mod	FUNERALC e of dying, such as cardia	HAPEL, 8	800 HARF	
P	hysician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only pro- lumediate Cause (Final	Right	DAriet	, Lhemore	lugic st	NKE	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseque					
	xaminer	-L	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	nce of):				
30/3	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
≥/633 8760,€	physicien and sthe burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):				
e/633 68760,	physic the bi	dicai	d.						
		n/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnance				23d. Date of deliv	very
20 B.	9 9 9	Physician/Me	in the past 12 months? 1 ☐ Yes 2 No	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown				Month	Day Year
76. P.O	nat me de led by the a detached i	Phys	9 ☐ Unknown Part II. Other significant conditions con-		ing in the underlying o	ause given in Part I	23e. Did toba	acco use contribute to	the cause of death?
08. ds, F	2 5 8	d by	Part II. Other significant conductions com	TIDENING TO GOALLY DUT NOT 10301	ang in the disconjing o	adoo givoir ii r airti.	1 ☐ Yes	. مد	obably 4 Unknown
ecor	× 0 0	Completed					24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of
3 4	0 2 0	mo					perform	ed? death?	2 No
Von	certificate	Be	25. Was case referred to medical examiner?	oenital:		Other	eath (Check only one		11 - 120
of ,	rnysicien: r this certific ral director,	To	1 Yes 2 No	ospital: 1 Inpatient 2 E		OA Wursing 18c. Injury at Work?	Home 5 Residen	- 11	(1) 10 Spice
ion :	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
AK PHIN Division	or Atte ter de lirecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factor	v, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
HANAE PHIN Division	spitel o		29a. Certifier 1 ☐ Certifying Phys	ician: To the best of my know	ledge, death occurred	at the time, date and pla	ce, and due to the car	use(s) and manner as	stated.
H .	To the Hospitel or Attending Prysicien: To the Foursel Siter dead. To the Foursel Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Examinate)	er: On the basis of examination and manner stated.	on and/or investigation	, in my opinion, death oc	curred at the time, dat	te and place, and due	to the cause(s)
	To t To ti com	Σ	29b. Signature and title of certifier	10		. License number		d. Date signed (Month	
	Λ		30. Name and address of person who op	mpleted cause of death (Item	23a) (Type Print)	D0300		TOJUS	18,2005
	3		So. Name and address of person will do	ey GBMC	6701 N	· Charles	J. Balto	114 21	20>
2.40	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	He Annu				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Romelle Hoff master State of Maryland / Department of Health and Mental Hygiene 05-04832 For State Registrar Reg. No.2 0 0 5 Certificate of Death NJM 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Romelle S. Hoffmaster July 2005 1358 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore City 329 South Clinton Street Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye JUL 15, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1□M 2€ F Months Yrs. 64 220-38-8832 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County 28a-fehow other traumatic event, the Mudical Examinar must be notified at 1 Yes 2 No Directo Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 329 S. Clinton Street 21224 USA or Iteme 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify. 3 ☐ Widowed 4 🛣 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Law Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental P Mollie Ε. Hoffman Michael Stacks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2120119a. Informant's Name/Relationship (Type, Print) Deborah L. Economas/Friend 20 S. Charles Street, Suite 1200, Baltimore, MD item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition jo ... 1 Burial 2 Cremation 3 Removal from State 0 Department of Important: If eny injury or once. Metro Crematory, Inc. 8/17/05 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Cremation Society of MD, Inc. MacNabb⁽ George E. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of) Examine use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 20ther (Specify) Medical Certification: To 1 TYes 2 □ No 2 ER/Outpatient 3 DOA Scene Ę. 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury sily it expend to 1 Natural BISHOZA death. investigation Accident 3 Suicide Heck hours after deal in 24 hour. the Funeral Director filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Beltimen, Kenylan de 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME July, 18, 2005 30. Name and address of person who completed cause death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE, MD 21201 THE UPORE MI For 32. Regis ar's Signature State AUG 1 2005 Registrar

CPM 05-05388 Robin Hoey

.11 .			1 - For State Registrar	State of	Marylar					and M	lental Hy	giene	5	271 77	
													3. Time of Death		
	Physici /Medic		Robin M. Hoey								August	09, 20	Year 05	17:55 M	
	Examin		4a. Facility Name (If not institution,	give street and numb	oer)		4b. City, T	Fown, or	Location of	of Death		4c. County of		1 11.00	
			3107 Lorena Ave	nue			В	alti	imore			n/a			
	Funeral			6. Sex 7. 1 ☐ M ※ ☐ F		last birthday)	If Under 1 Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birtl (Month, Day	r, Year)	9. Birthp	place (State or Foreign	
-	Director		216-96-3154 Usual Residence of Decedent		36	Yrs.					Nov.1,	1968	MD		
	land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limits	
	Man,	ţ	MD n/	^l a	Balt	imore								MXYes 2 No	
	r 28s	Director	10e. Street and Number				10f. Zip (Code				10g. Citizen of Wi	hat Coun	ntry?	
	deeth with the Maryland ims 23a or 28a-f ehow f.must be notified at	aiΩ	519 South Cator	Ave.			212	229				USA	A		
	eep .	Funerai	11. Marital Status	l.S. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A Black, V						- Americ , White,				
90	or It	Y.F.	1 Never Married 2 Marrie	d 1 ☐ Yes 2 If Yes, Give	1 ☐ Yes 2X☐ No			1□Yes 2℃No Specify: White				Specify:	ite		
Š	hour:	ed by	3 Wildowed 4 Your or Dates:												
쟌	n 72 "na"	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of wife. DO NOT use retired)						t of work	vorking 16b. Kind of Business/Industry					
72	with iene.	mo	Selementary/Secondary (0-12) College (1-4or 5+) Homemaker							Home					
ਰੂ	Hyg othe	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	First, Middle,	Maiden Sumame			
<u> a</u>	Ald be Alenta rked tic ev	To B	Frank Rihtaric						Linda	Mic	hal				
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylan Dependent of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Inportment: If them 27 is marked other than "naturel; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at 90cc.	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address ((Street a	and Numbe	r or Rur	al Route Numbe	r, City or Town, S	tate, Zip	Code)	
Σ.	end 2 palth n 27		Malinda S. Riht	aric- Dau	ghter	519 S	outh (Cato	n Ave	. Ba	ltimore	. Maryla	ind 2	21229	
Baltimore,	of H		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		20b. F	Place of Dispo cemetery, cren	sition (Name natory or oth	e of her plac	θ)	(Date	20c. Location - C	ity or To	wn, State	
Ĕ	Pag ment ent: ury c		4 □ Donation 5 □ Other (Spe	ecify)	Lou					-		altimore		2	
3aH	permit. Depart Import any In		21. Signature of Euneral Service Li	censee								k Funera			
_	00 = e d		500 Wilkens Ave, Baltimore, Maryland 21229										21229		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one rause on each line. Approximate Interval Between Onset and Death												
	Physician		Immediate Cause (Final disease or condition resulting in death) a. ASPAYKA										Onset and Death		
	/Medical Examiner		resulting in obatiny	Due to (or	as a conseq	uence of):									
	*	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):												
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•	al-tra	Xai									-				
8760,	cate be executed bhysicien and the burial-transit	dicail													
68	tificate ig phys es the	ledi													
Вох	leath certific attending pl	M/us	IF FEMALE: 23b. Was decedent pregnant 1 I we high 2 Settled each 3 Settled exception								23d. Date of			,	
Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1							Month			Day Year					
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<u>(v</u>	igned be dal	Completed by I	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								11	23e. Did tobacco use contribute to the cause of death?			
oro.	w requir been s should										1 Yes 2 No 3 Probably 4 U			ably 4 Unknown	
ec	e lew hes b	de l									24a. Was a autops	y pri	24b. Were autopsy findings available prior to completion of cause of		
Z e g e g e g e g e g e g e g e g e g e								med? de 2 ☐ No 1)	death?						
<u> </u>	Physician: The this certificate ral director, pag	Be													
5	Phys	5	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6/20ther (Specify) 50												
5	ding Phy th. After this funeral o	盲	1 □Natural 5 □ Pending (Month, Day Year) Injury P						Work?			28d. Describe how injury occurred Subject was			
S Suicide 3 Suicide 4 Homicide 6 Could not be determined 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Halv norms								1100 2410					Route Number		
								State) 3107 Livery Aug.							
	splta hours ineral / fillex		29a. Certifier 1 Certifying	Physician: To the be	est of my kno	wiedge death	occurred at	t the tim	e, date and	d place.	But time to the c	ause(s) and mann	ner as sta	ated.	
	ne Hc n 24 l ne Fu yletely	edical	(Check only 2 A Madical Ex	xaminer: On the basi and manner	is of examina	tion and/or inv	estigation, i	in my op	inion, deat	h occurr	ed at the time, d	ate and place, an	d due to	the cause(s)	
	29b. Signature and title of certifier 29c. License number 29c.								9d. Date signed (Month, Day, Year)						
	Paneth Douthell no						O.C.M.E. Aug					August 1	gust 10, 2005		
	2		30. Name and address of person w		of death (Iten									~-	
			Pamela E. Sc)		Penn	Stre	et, I	Balt:	imore, M	laryland	2120	01	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Res	istrar's Signa	ture	beele	,							

DHMH 17 Rev 1/2001

ORIGINAL

				State of Maryland /					•			
			1 - For State Registrar	Death	Reg. 2005 27179							
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death		
	Physici: /Medic		Caroline		August	11, 2005	5:20 P.M					
	Examin		4a. Facility Name (If not institution, give s	treet and number)	r Location of Death		4c. County of Dea					
		12	14 Locust Drive Catonsville 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 H						Baltimore			
	Funeral		5. Social Security Number 6. Sex		rthplace (State or Foreign ountry)							
	Director		213-10-5823 91 Yrs. April 17, 1914 Canada Usual Residence of Decedent									
	yland		10a. State 10b. County	10c. City, Tov	n or Lo	cation				10d. Inside City Limits		
:	a-fat	ctor	Maryland Baltimore	Catons	Le				1 ☐ Yes 2½ No			
:	or 28	Director	10e. Street and Number	-		10f. Zip Code			10g. Citizen of What C	ountry?		
	ain w	rai	14 Locust Drive				21228		USA			
	itams itams	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh			
5	irs and	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 TNo Specify:			Specify: W	hite		
2	illed within 72 hours after death with the Maryland Hygione, within "naturel; or items 23s or 28s-f show ant, the Medical Examinar must be mailfied at	ted	15. Decedent's Educ	ation		16b. Kind of Business	b. Kind of Business/Industry					
	Med I	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)			ang	Maryland	State		
V	ygian yer th	Con	12	33 11.111		Secretary				ministration		
= .	d oth	Be	17. Father's Name (First, Middle, Last)		ner's Name (First, Middle, Maiden Sumame)							
710	should be filed with and Mental Hygiene is marked other that sumatic event, List	T _o	John Unknown 19a. Informant's Name/Relationship (Type					Unknown Rural Route Number, City or Town, State, Zip Code)				
-	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. If Health and Mental Hygiene. Item 21 is marked other than "naturel", or Itams 23a or 28a-f show them 21 is marked other than "naturel", or Itams 12a or 28a-f show other traumatic event, Ita Medical Examination must be militied at	Ì	Bertran T. Harris									
ט .	s 1 and F Health Item 27 other tr	1 3	20a. Method of Disposition			sition (Name of natory or other place		Date	20c. Location - City o	Town, State		
	permit. Pages 1 and 2 Department of Health a Important: if item 27 it any njury or other tra once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Loudo	n Pa	ark Cemet	ery 8/10	6/05	Baltimore,	Maryland		
	Departm Departm Imports any nju		21. Signature of Funeral Service License	9 - Fred State Sta	ss of Facility Lo	oudon Pa	rk Funeral	Ноте				
0	8 3 E 8 8		3620 Wilkens Ave., Baltimore, MD 21229									
	in the		23a. Part1. Enter the disease, or complication hock, or heart failure. List only on	cations that caused the death. Do e cause on each line.	not ente		()			Approximate Interval Between		
	hysician		Immediate Cause (Final disease or condition	Corena		Onset and Death						
	/Medical Examiner		resulting in death)	Due to (or as a consequence	en	View I						
	T.	P.	Sequentially list conditions,	Due to (or as a consequence	~; · · · · · · · · · · · · · · · · · · ·	~ (Q\P)			7-3			
pa.	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury									
5	e be executed /sician and e burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):									
20/0	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Ical	€ d									
00	ing ph	Med	IF FEMALE:									
ַב מ	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal deat	Ectopic pregnancy		23d. Date of de Month	livery Day Year				
- 5	The law requires that the death certifical aite has been signed by the attending phypage 2 should be detached for use as the	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown								
Ľ	that the by detact		Part II. Other significant conditions con	tributing to death but not resulting	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?				
cords,	quires n sign	d by	Recent myorardial infusion 1010							s 2 No 3 Probably 4 Minknown		
วิ	sw rec	Completed	Cof D 24a						Was an autopsy findings available prior to completion of cause of			
ב	The la	mo:						autop perfor	med? 🦯 📡 death?	completion of cause of		
	artifica ctor, p	Bec	25. Was case referred to medical examiner?				26. Place of Deat					
5 7	hysic his ce il dire	To	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/O		4 Nursing no	ng Home 5 Residence 6 □Other (Specify)					
	Aiter t	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?				28d. Describe h	ow injury occurred	injury occurred		
	death death stor: , the f	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Ye 28e. Place of Injury - At home, farm, street, factory, office			Yes 2 No		on (Street and Number or Rural Route Number,			
	after Direction by	Certification:	4 Homicide determined	building, etc. (Specity)	arm, suc	ser, ractory, onice		City or Tow	n, State)	urar noute rearriger,		
	sprte hours ineral filled		29a. Certifier 1 CertifyIng Phys	ician: To the best of my knowledg	e, death	occurred at the tir	ne, date and place,	and due to the o	cause(s) and manner a	s stated.		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Alter this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examination)	er: On the basis of examination a and manner stated.	nd/or inv	estigation, in my o	pinion, death occur	red at the time, o	date and place, and du	e to the cause(s)		
	To t	Σ	29b. Signature and title of certifier	A. A.	Hen	29c. Licens		2	29d. Date signed (Mon	th, Day, Year)		
	•		Buyan	Fur.	My	2) 3674	_	Hypers L 1	4,2005		
	6		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Туре,	Print) Rd.	Cotony	ste, s	August 1	28		
	Sta	te	31. Date filed (Month, Day, Year)	32. Refistrar's Signature		4						
	Renistr		ALIC 1 0 20	105 6	1	M						

			For Stata Registrar	State of N	Maryland /		of Health and M of Death	lental Hygie	_	27180
	Physician /Medical 1. Decedent's Name (First, Middle, Last) HENRY					HERLING		2. Date of Death Month	Day Year	3. Time of Death 7:45 PM
32.67.03	xamine	_	4a. Facility Name (If not institution, give	7 1 0	Himora		wn, or Location of Death (Limore (ity	4c. County of Dea	N/A
	neral ector			x 7 X M 2□F	Age (In yrs. last b 92	irthday) If Under 1 \		8. Date of Birth (Month, Day, Y) DEC. 5,	1912 9. Bi	nthplace (State or Foreign ountry) MD
aryland	in pa	7	Usual Residence of Decedent 10a. State 10b. County	TMODE	, ,	wn or Location				10d. Inside City Limits
rling deeth with the Maryland	e notifie	Funeral Director	MD BALT 10e. Street and Number		BALTIMORE 10f. Zip Co	ode	10g	. Citizen of What C	1 ☐ Yes 2 😿 No ountry?	
Herling 36 s atter death with the	munt	erai	9 HALCYON COURT	12. Was Deceder	nt Ever in U.S.	13. Was Deceden	21208	acify Yes or No-	14. Race - Am	USA erican Indian
0 5	edical Exercicar must be redified at	þ	1 ☐ Never Married 2(X) Married 3 ☐ Widowed 4 ☐ Divorced	Amed Force 1 X Yes 2 [If Yes, Give Year or Date:	□No	If Yes, specify 1 ☐ Yes 2[X	t of Hispanic Origin? (Spe Cuban, Mexican, Puerto No <i>Specify:</i>	Rican, etc.)	Black, Whi	
15-0036 in 72 hours at		Completed	15. Decedent's Ed (Specify only highest grad	de completed)		a. Decedent's Usual C (Give kind of work of life. DO NOT use r	fone during most of worki	ng 16	b. Kind of Business	√Industry
d 2121 d 2121 Hygiene.	nt tre		Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4o	(WNER		(First, Middle, Mai	GROCER	
Maryland 212:	other treumatic event, the M	To Be	ISAAC		H	IERLING	LEAH	(First, Middle, Mai	den Sumame)	SCHERR
Z 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	tre		19a. Informant's Name/Relationship (7 BEA HERLING / WI		g	HALCYON (treet and Number or Rura			Zip Code)
Baltimore, permit. Pages 1 ar Deperment of Hea	y or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify				of rplace) SOCIETY MEMORIAL 8/		C. Location - City or	
Baltimore, permit. Pages 1 an Deperment of Heal	any Injur once.		21. Signature of Funeral Service Licens		TILDIKE	22. Name and A	ddress of Facility SOL	LEVINSON		, INC.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caus	ed the death. Do		STERSTOWN R f dying, such as cardiac o			Approximate Interval Between
	dical		Immediate Cause (Final disease or condition resulting in death)		ower of	GI Blex	ed			Onset and Death
Exan	. 3	er	Sequentially list conditions,	b. Due to (or a	is a consequence	i offic				
60, be executed	the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	is a consequence	of):				
8760 cate be o	he bu	Ca		d						
O è è	detached for use es th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal deat at time of death	h 3 Ectopic pregn 5 Other (specif			23d. Date of de Month	livery Day Year
LS, P.(peq .	<u>م</u>	Part II. Other significant conditions co	ntributing to death	N -	in the underlying caus	e given in Part I.			the cause of death?
COCC aw requi	2 should	Completed	COTONATU) Artier	y Disc	use .		1 Tes	24b. Were au	robably 4 Unknown utopsy findings available
al Rec	funeral director, page	e Com	25. Was case referred to medical					autopsy performed 1 Yes 2	prior to death?	comptetion of cause of
of Vital F Physicien: Th	directo	0 10	examiner?	Hospital: 1 Inpa	tient 2 ER/O	utpatient 3 DOA	26. Ptace of Death Other: 4 ☐ Nursing Hon	Check only one one 5 Residence	e 6 □Other (Spe	cify)
Division of Vital Records, or Attending Physicien: The law requires to after death.	e tunera	ation:	27. Manp of of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, L	jury 28b. Day Year)		Injury at Work? 1 Yes 2 No	8d. Describe how i	njury occurred	
Divis lor Atte	d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At home, f etc. (Specify)	arm, street, factory, of	fice 2	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ural Route Number,
Divisio To the Hospitel or Attendi within 24 hours after death.	completely tilled in by the	dicai	29a. Certifier (Cneck only one)	sician: To the bes	or examination a	e, death occurred at the	l ne time, date and place, a my opinion, death occurre	and due to the cause ad at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within	сошр	<u> </u>	29b. Signature and title of certifier		Stateou.		cense number		Date signed (Mont	
12		1	30. Name and address of person who c	ompleted cause of	death (Item 23a)	(Type, Print)	8386	Au	gust, 15	5, 2005 MD 21215
1	Stat	e	31. Date filed (Month, Day, Year)	Carin 32. Progis		2401	West Belve	deve, B	altimore.	MD 21215
ROHMH 17.6	egistra	46	AUG 1 9 20	105	eur St	Sparke				-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Vear Charles Hampton 2005 /Medical August 8:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville

If Under 1 Year | If Under 24 Hrs. |

Manchel Days | Hours | Min. | Crescent Cities Center Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Yrs. Director 247-34-5263 02/08/1930 South Carolina Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Exeminar must be notified at MD Prince George's Director Glenn Dale 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8017 Wingate Drive 20769 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No 1947 If Yes, Give 1946 Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1848 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Black ģ 3 ☐ Widowed 4 N Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Music Therapist Health Care 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If Item 27 Is marked oth any july or other traumatic event <u>QDCB</u>. 18. Mother's Name (First, Middle, Maiden Sumame) Governor Hampton Ethel Mae Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Ellis, Sister 8017 Wingate Drive, Glenn Dale, MD 20769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 08/20/2005 Brentwood, Maryland 21. Signature of Furieral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd, Brentwood, MD 20722 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Wound Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine signed by the attending physician and d be deteched for use as the burial-transit Urinary Tract Infection that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: ဠ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or ignestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D48077 August 18, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Alexander Ukoh, MD,

31. Date filed (Month, Day, Year) AUG 1 9 2005

32. Registrar's Signature

4404 Queensbury Road, Riverdale, MD 20737

Dave

		1	For State Registrar	State of Mar		artment of H			ene g. N2 0 0 5	27182
4		7.	Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia		Margaret L. Hy	land				August		1:45P M
	/Medic Examin	160	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Deat	th
			Mariner Healthcar	e of Bethes	da	Betheso	la		Montgom	ery
0 to 10	Funeral		5. Social Security Number 6. 5	Sex 7. Age (In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign
	Director		044-01-1863	1□ M 2XF	90 Yrs.			April 2	8, 1915 Cor	nnecticut
	<u> </u>		Usual Residence of Decedent 10a. State 10b. County		IOc. City, Town or L	ocation				10d. Inside City Limits
	anylar show	_	10a. State 10b. County							1 X Yes 2 □ No
	Ba-f	cto	Maryland Montgon	nery	Chevy Cl			10	g. Citizen of What Co	unta/2
	i	Dire	10e. Street and Number			10f. Zip Code				
	death with the Maryland ms 23a or 28a-f show ir must be invitted at	Funeral Director	5555 Friendship I		737	20815	lanania Osiaina (Sa		United Sta	
	er de	nne	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Whit	
20	s afte	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: Wh	nite
0500-G17	hour turel		15. Decedent's E		16a. Dec	edent's Usual Occup	ation		6b. Kind of Business	
Ċ	in 72	Completed	(Specify only highest gr	ade completed)	(Giv	e kind of work done DO NOT use retired	during most of work	king		
7	with ene.	E	Elementary/Secondary (0-12)	College (1-4or 5+	Exec	utive Sec	retary		Import/Exp	ort Business
Ö	Hyg Hyg other	Be C	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	e (First, Middle, N	faiden Sumame)	
<u>a</u>	id be ental ked ic ev	To B	Lawrence Hyland				Bridget	te Keale	У	
Maryland	of 2 should be filed within 72 hours after death with the Marylan thand Markla Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Medical Examiner must be indiffed at		19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Street	and Number or Rui	ral Route Number,	City or Town, State,	Zip Code)
2	nd 2 alth a 27 is		John R. Cashin,	Jr./Nephew	412	Beaumont			ng, Maryla	and 20904
ō,	is 1 and 2 of Health a item 27 is other trai		20a. Method of Disposition		20b. Place of Disp cemetery, cr	oosition (Name of ematory or other plac	Augu	St 15,	20c. Location - City or	Town, State
Ē	Pages nent of int: If its iry or o		1 □ Burial 2 ♣ Cremation 3 € 4 □ Donation 5 □ Other (Spec		Montgome	ry ium. Inc.	2005		Bethesda,	Maryland
Baltimore,	permit. Pages Department of I Importent: If its any injury or o		21. Signature of ral Service Lice	esee	D	22. Name and Addre	ss of Facility Rob	ert A. T	umphrey Fu	neral Home/ onsin Avenue
ñ	Deg man	0	1 Sind	eur.	M00803 B	ethesda,	Maryland	20814-3	501 wised	onsin Avenue
7	49		23a. Part1. Enter the disease, or cor shock, or heart failure. List on	nplications that caused t	he death. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final			iomyopath	v			Onset and Death
	/Medical		disease or condition resulting in death)	W	consequence of):	Tomy opach	,			
	Examiner			Pneumo	nia					
10	\$ P	ĕ	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	c						
ó	te be executed ysicien and ie burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
760,		cal		d						
9	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as t	Physiclan/Med	IF FEMALE:			*				
Вох	it the death cer by the attendir tached for use	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1 ☐ Live birth 2	Fetal death 3	□Ectopic pregnanc	y		23d. Date of de Month	blivery Day Year
<u>о</u> . П	ne dea the at hed fo	sicl	1 ☐ Yes 2 ☐ No	4☐Pregnant at t 9☐ Unknown	ime of death 5	Other (specify) _				,
<u>Р</u>	at the i by ti stach	Phy	9 Unknown			daskina savas su	on in Bort I	23a Did toh	acco use contribute t	o the cause of death?
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ğ	v requir been s should	ted								
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<u> </u>		Completed						perform	ned? death? ∑∑No 1 ☐ Ye	s 2 No
Vital Records,	Physicien: The this certificate har ral director, page	Be (25. Was case referred to medical examiner?					ith (Check only on	e)	
of <	hysic this ce al dire	2	1 ☐ Yes 2X No	Hospital: 1 Inpatier		ient 3 DOA	- Incolair		ence 6 Other (Spi	scify)
n o		on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injun	/ Wa		28d. Describe no	w injury occurred	
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Division		Certification;	4 Homicide determine		ry - At home, farm, . (Specify)	street, factory, office		City or Town	, State)	Rural Hoole (Vulliber,
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	To the Hospitel or Attent within 24 hours after death within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 X Certifying 1 (Check only 2 Medical Ex	Physician: To the best o aminer: On the basis of	examination and/or	investigation, in my	opinion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner stat		29c. Licen	se number	2	9d. Date signed (Mor	nth, Day, Year)
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/	N		verpena				7660		August 15	, 2003
1	Ý		30. Name and addless of person w				#C100 P	ockwillo	Maryland	20852
	- A C	ate	Alpana Goswamu,	32. Registra	9 KOCKVIJ r's Signature	re rike,	"GLOU, KO	OCKATTTE,	патутани	20032
80	St Regist		AUG	G 1 9 2005	Blazur 1	15 April				
	and the second					9				

				partment of Health and ertificate of Death	Mental Hy	giene Reg. No 2005	27183
	Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Dea	ath	3. Time of Death
	/Medi		Robert Ellis Hoe	rner, Sr.	Month	Day Year t 12, 2005	2:50 P M
7	Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death	
			7561 Ives Lane 5. Social Security Number 6. Sex 7. Age /in vrs. /act highday	Dundalk		Baltim	ore Co.
	Funeral Director		1₩ 2□F	Months Days Hours Min	. (Month, Day	y Year) 9. Birth	nplace (State or Foreign
			201-16-3918 Yrs. Usual Residence of Decedent		May 4,		nsylvania
	yland		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mar	ţ	Maryland Baltimore				1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number	10f. Zip Code		log. Citizen of What Cou	
	hours after death with the Maryland turel', or Items 23a or 28s-f show al Examinar must be notified at	aD	7561 Ives Lane	21222			•
	ee E	by Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer		United St	
õ	or it	E	TENTOS ZENIO		to Rican, etc.)	Black, White	, etc.
ğ	ural',	d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates: Korean	1 ☐ Yes 2 ☑ No Specify:		Specify:	White
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "natural", or Itema 23a or 28e-f show avent, Ira Madical Examinar must be notified as	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wo	dring	16b. Kind of Business/ir	ndustry
7	within 72 ene. then "nai	Ę	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	, wild	Internation	
	Hygie other	ပ္ပ	12 Years 17. Father's Name (First, Middle, Last)	Printer		Paper Compa	any
yland	ntai d o d o	Be		18. Mother's Na	me (First, Middle, I	Maiden Sumame)	
2	should and Men marke	2	Earl Hoerner 19a. Informant's Name/Relationship (Type, Print) 19b. Maili		ryn Rabuc		
Mar	d 7 Le 17 Le			ng Address (Street and Number or Ri	ural Route Number	City or Town, State, Zip	o Code)
a)	s 1 end 2 f Heelth Item 27 other tre			Ives Lane Dund			
altimor	permit. Pages Depertment of H Importent: If Its eny injury or of once.		1 Burial 2 Cremation 3 Removal from State	matory or other place)		20c. Location - City or To	own, State
	iit. Portme			ll Mem. Gdns. 8/1	6/2005	Middle Riv	er, MD
מ	Depermine Deperm			2. Name and Address of Facility Ouda-Ruck Funeral	Home of	Dundalk Tr	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	922 Wich Arra Da	-1 F - 5 m		222
	Physician /Medical Examiner	Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfully Cause (Disease or injury that inflicted exercise.	ncer			Approximate Interval 8etween Onset and Death
00,00,00	Expense of Augmenting Prystrian; The law requires their the death certificate be executed to hours affect death. Funeral Director: After this certificate hes been signed by the attending physicien and lely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dical	resulting in death) Last Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of delive	on.
	of the deal by the a stached for	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month	Day Year
ĵ i	signed to be dat	ል	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.	23e. Did tob	acco use contribute to th	e cause of death?
5	been si should	Completed			1 ☐ Yes	2 □ No 3 Prob	ably 4 Unknown
	hes by	읊			24a. Was an	24h Were autor	osy findings available
i	ete h page	5			autopsy perform	ed? prior to con death?	npletion of cause of
	ctor.	Be	25. Was case referred to medical examiner?	26 Place of Dead		XNo 1 ☐ Yes	2 No
	nya ce	0	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	O4	h (Check only one	ce 6 ☐Other (Specify	
	fter ti		27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	28d. Describe hov)
	or: A	atic	2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,	
	after de la Direction de la by t	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
Hospie	within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cau	ise(s) and manner as sta	ited.
	omple	ğ	29b. Signature and title of certifier	29c. License number			
-	->=0		Ahuron Balanson	D 0 0 5 5 1 5 7		J. Date signed (Month, E	
	_,		30. Name and address of person who completed cause of death (Item 23a) (Type, P			8/16/200	5
5	11		9600 North Point Rd, Fu	rint) rt Howard	MD	21052	
	State Registra	-	31. Date filed (Month, Day, Year) AUG 1.9 2005 AUG 1.9 2005	E)			

		For State	State o	f Marylar		artment of H		d Menta		0000	07101
		Registrar 1. Decedent's Name (First, Middle.	Last)		001	inicate of	Death	2 Date	Reg. N	8 000	3. Time of Death
Physici /Medic		Minh Ho			,			Au g	gust 15		3:35P M
Examin	er	4a. Facility Name (If not institution,	-	mber)		4b. City, Town, o	or Location of D	eath		c. County of Dea	
		9229 Falls Cha		7.4.4		Potomac		Hea I a =		Montgom	
Funeral Director		5. Social Security Number 215-21-7040	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 83	Yrs.	If Under 1 Year Months Days		din. (Mo	e of Birth nth, Day, Year :11 20,	9. Bi 1922 Vi	rthplace (State or Foreign country) etnam
pui		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	antion					10d. Inside City Limits
sho	5	Maryland Montgo	merv		Potomac						1 ☐ Yes 2X No
the N	ect	10e. Street and Number	mer y			10f. Zip Code			10= 0	itizen of What C	
with or	Funeral Director	9229 Falls Chap	el Wav			20854				etnam	ountry ?
eath	era	11. Marital Status		edent Ever in U	S 13 V	Was Decedent of I		? (Specify Ve		14. Race - Am	erican Indian
r Iten	Fu	1 ☐ Never Married 2 ☐ Marrie	Armed Fo	orces?		f Yes, specify Cub	an, Mexican, P	uerto Rican, e	etc.)	Black, Whi	
ours after death with the Marylar al, or Items 23a or 28a-f show Even in er must be modified at	by	3 X Widowed 4 ☐ Divorced	ed 1 ∐Yes If Yes, Gi Year or D	ve 22 ates:		1□Yes 2 X No	Specify:			Specify: A	sian
	Completed	15. Decedent' (Specify only highest			16a. Deced	dent's Usual Occup	pation	working	16b.	Kind of Business	s/Industry
be filed within 72 horal Hygiene. Id other than "natuevent, the Medical	nple	Elementary/Secondary (0-12)	College (kind of work done DO NOT use retire	d)	Norking			
ygier ygier her th	Co		<u> </u>		Homem	aker				wn Home	
be fill tal H od ott	Be	17. Father's Name (First, Middle, L Chau Viet Ho	ast)					_{Name (First,} 'hi Ngu	Middle, Maide	n Sumame)	
y Mould	ပ			_							
permit. Pages 1 and 2 should be filed within Department of Health and Mahala Hygiene. Important: if item 27 is marked other than any injury or othar traumatic event, Item Mapages.		19a. Informant's Name/Relationsh Phuoc Thi Nguye		nter		ng Address <i>(Str</i> ee) Falls Ch					
s 1 and the street of the stre		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other pla	(9) 1116	Date 19	20c. I	Location - City or	r Town, State
Page nent c int: If		1 ☐ Burial 2 🂢 Cremation `4 ☐ Donation 5 ☐ Other (Sp		State	-	Crematoriu	m Inc	2005	Bet	hesda, M	faryland
mit. ports ports y inju		21. Signature of Funeral Service t	îcensee		R 22	. Name and Addre	ess of Facility R	obert	A. Pum	phrey Fi	uneral Home/ onsin Avenue
3 88 E 8 8				<u>мо</u> 1	1433 Be	thesda,	Marylan	d 2081	4-3561	J/ WISC	Siistii Aveilue
		23a. Part1. Enter the disease, or c shock, or heart failure. List of	complications that	caused the deat	th. Do not ente	er the mode of dyi	ng, such as car	diac or respir	atory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Lung	Cancer	<u>.</u>						Onset and Death 6 Months
/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):						
Examine	_	Sequentially list conditions,	b	,							
led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consec	quence or):						
be executed ician and burial-transit	хап	that initiated events resulting in death) Last	c	(or as a consec	juence of):						
te be executed ysician and e burial-transit	dical E										
fficate g physics the	edic		O								
eath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna						23d. Date of de	elivery
death e atte	icia	in the past 12 months? 1 ☐ Yes 2 🕅 No	4□Pregi	birth 2 ☐ Feta nant at time of c]Ectopic pregnanc] Other (s <i>pecify</i>) _	у			Month	Day Year
by the tached	Physician/Me	9 🗆 Unknown	9□ Unkn	own							
The faw requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the	ру Р	Part II. Other significant condition	ns contributing to d	leath but not res	sulting in the ur	nderlying cause gr	ven in Part I.	236			to the cause of death?
w require been si should I								-	1 Yes	2 ∆ No 3□P	robably 4 Unknown
as be	Completed							248	a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
The tate has page	Corr							1	performed? Yes 2X N	death?	s 2 No
sician: Th certiticate rector, pag	Be (25. Was case referred to medical examiner?						Death (Check	k only one)		
physic this o	ပ	1 ☐ Yes 2 X No			ER/Outpatien					6 ☐Other (Spe	ecify)
ing P	lon	27. Manner of Death 1 X Natural 5 □ Pending		of Injury hth, Day Year)	28b. Time of Injury	Wo		28d. De	scribe how inju	ury occurred	
tend death tor: /	cat	2 Accident investig 3 Suicide 6 Could n	ot be	f laine - AA la			Yes 2 No	006.1	-4: /044		
To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	4 Homicide determine	ned 289. Place build	ing, etc. (Specia	fy)	eet, factory, office		City	or Town, Sta	ina Number or H te)	lural Route Number,
spita ours neral filled		29a. Certifier 1X Certifying	Physicien: To the	e best of my kno	owledge, death	occurred at the ti	me, date and p	ace, and due	to the cause(s) and manner a	s stated
To the Hospital or within 24 hours afte To the Funeral Dis completely filled in	Medical	(Check only 2 Medical E	:xaminer: On the b	pasis of examina ner stated.	ation and/or inv	estigation, in my	opinion, death o	occurred at the	e time, date ar	nd place, and du	e to the cause(s)
To th within To th	MĚ	290. Signature and title of certifier	^			29c. Licen:				ate signed (Mon	
11.	1	· aunt	ris			D37	891		Aug	ust 16,	2005
2		30. Name and address of person v					041		- 36	_1 _ 1 00	2002 F276
0		Amit Rajvanshi, 31. Date filed (Month, Day, Year)		I Georg: Registrar's Signa	atura			Sprin	ıg, Mar	yland 20	1902-52/6
Sta Registr		S1. Date filed (Month, Day, Year)		RO'	5	Proceeds.	1				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend item # 5 Per fh g847 9 profiles op Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Amonth August **Physician** acy 7005 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore-Washington Hosp. Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 215-52-6224 **Funeral** Months Days Hours 1 □ M 2 및 F 216-62-5310 Director June 22,1953 New York Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "netural", or items 23s or 28s-1 show other traumatic event, the Modical Examinar must be notified at Maryland Anne Arundel 1 Yes 2 No Glen Burnie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 297 Scotts Manor Dr. 21061 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after upon of Health and Mental Hygiene. Int: If item 27 Ia marked other than "netural", or item 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel J. Salem Florence L. Robertson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arthur L. Jenkins, Jr./Husband 297 Scotts Manor Dr., Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of himportant: If ite any injury or of once. 1 Wurial & Gremation 3 Pemoval from State August 20 Cedar Hill Cem. * 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn Park, Maryland 2005 21. Signature of Fune. I Service I censee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) VACLIF Physician | /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in dealh) Last Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 Yes 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home r this r 1 Yes 2 No 12 Inpatient 10 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No Director: A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours are To the Funeral Dir 29a. Certifier 🗺 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, ame and address of person who completed cause of death (Item 23a) (Type, Print) Dive 7-O 32 Aegistrar's Signature 31. Date filed (Month, Day, Year) State 9 2005 Registrar AUG 1

				State of Maryland / 3a per Dr., C846,	Depa 08/ 08/	rtment of H 9/05dhb tificate of L	ealth and Death		ene 2005	27186
П	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic				Jenn	ings			29 2005	1:15 p M
	Examir	er	4a. Facility Name (If not institution, give			4b. City, Town, or		h	4c. County of Dea	ith
			Future Care Cherr 5. Social Security Number 6. Sec		nirthday)	Reister If Under 1 Year	rstown If Under 24 Hrs	8. Date of Birth	Balto	thplace (State or Foreign
	Funeral Director			M 2□F 91	Yrs.	Months Days	Hours Min.	(Month, Day, 1	rear) C	ountry)
			Usual Residence of Decedent	91				10-12-	1913	S.C.
	rylan how		10a. State 10b. County	10c. City, To		cation				10d. Inside City Limits
	Ba-f s	cto	Md N/A	Bal	to					1 X Yes 2 No
	ith th	Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of What C	ountry?
	ath w	iai	2815 Keyworth Ave			212			USA	
21215-0036	d within 72 hours after death with the Maryland Jiene. r than "natural", or itams 23a or 28a-f show the Medical Esantinar fount be Excitled at	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	l li	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	
Ö	2 hou	ted	15. Decedent's Edu	cation 16	a. Deced	ent's Usual Occupa	ition	16	3b. Kind of Business	/Industry
215	within 7 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of OO NOT use retired	luring most of wo)	rking	B.O. Rai	lroad
2	filed withi Hygiene. Ither than	FO.	7th grade	N/A	Eng	ine Clear				
ם	be filed ttal Hygie of other	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma	aiden Sumame)	
yla	should be tind Mental Is marked or umatic eva	ပို	Venson Jennings					obinson		
Maryland	0 8 8	1	19a. Informant's Name/Relationship (Ty					ıral Route Number, (Zip Code)
	s 1 and 2 if Health itam 27 other tra		Louise Jennings -	The second secon	1000	Keyworth	Avenue	-	Md 21215	T
Baltimore,	Pages 1 nent of H int: If its		20a. Method of Disposition 1 ♥ Burial 2 □ Cremation 3 □ F	emoval from State cemet	ery, creп	natory or other place	1		oc. Location - City or	Town, State
Ħ			4 □ Donation 5 □ Other (Specify)21. Signature of Runeral Service Licens		-	1 Cemeter			Balto, Md	
Bal	permit. Departr Importe any inju		21. Signature of Roheral Service Licens	1	22	Name and Addres		March F/H Avenue	West Balto, Mo	1 01015
	-		23a. Part1. Ent ir the disease, or compl	utions that caused the death. Do	not ente					Approximate
58760,	Physician / Medical Examiner but sician and	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Hypertension Due to (or as a consequence Renal Diseas Due to (or as a consequence	n e of): se	Ren				Onset and Death
.O. Box (The law requires that the death certificate ate has been signed by the attending physoge 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√□ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
0_	w requires that been signed b should be deta	by	Part II. Other significent conditions cor	ntributing to death but not resulting	in the ur	iderlying cause give	on in Part I.	23e. Did toba		o the cause of death?
Vital Records,		e Completed						24a. Was an autopsy performe 1 🗆 Yes 🏖	prior to	utopsy findings available completion of cause of
₹	Physician: rthis certifical ral director, p	o Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/C	Literation	3 DOA Othe	r + 1	ath (Check only one)		city HOSPICE
ion of		H	27. Manner of Death Natural 5 Pending 2 Accident investigation	T	Time of Injury	28c. Injury Work		lome 5 ☐ Residen 28d. Describe how		cony Restrict
Division	Hospital or Attending 44 hours after death. Funeral Diractor: Afte tely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or Atterville of Atterville 24 hours after de To the Funeral Directe completely filled in by the	Medical	29a. Certifier 1 Medicel Exemione) 2 Medicel Exemi	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death and/or inv	occurred at the timestigation, in my op	e, date and place inion, death occu	e, and due to the cau irred at the time, date	se(s) and manner as and place, and due	s stated. a to the cause(s)
þ	V Killing To Control of the Parket of the Pa	×	29b. Signature and title of certifier	B Cl	+()	29c. License	2 (e 80	1. Date signed (Mont	1, day, Year) 2005
_			30. Name and address of person who co	mpleted cause of death flem 23a	CS.	NEC	ع مالا	BULT	MORE	MARY (ACT)
	Sta Registi	-	31. Date filed (Month, Day, Year) AUG 1 9 2005	32. Registrar's Signature	1024	U.				21215

	1	State of Maryland / Dep 1 - State Unpend Item 23a, pt.II, 27, 28a - F. J. 1. Decedent's Name (First, Middle, Last)	artment of Health and Mental per me G847 9-1-05 tas rtificate of Death		1 8 7
Physician /Medical Examiner		Rachel Jean Kincaid 4a. Facility Name (If not institution, give street and number)	Month AUGU 4b. City, Town, or Location of Death	Day Year 205	
Funeral Director		MARYLAND GENERAL HOSPITAL 5. Social Security Number 237-58-6788 1 M 2XD F 67 Yrs.	BALTIMORE If Under 1 Year If Under 24 Hrs. Min. Months Days Hours Min. FEB	of Birth n, Day, Year) 28 1938 Sinthplace (S Country)	State or Foreign
Ba-f show ciffied at		Usual Residence of Decedent	nore	17.	ide City Limits]Yes 2 ☐ No
ritema 23a or 28a-fa Urar mast ke notified Funeral Director		10e. Street and Number 303 W. 31st Street 11. Marital Status 12. Was Decedent Ever in U.S. 13.	10f. Zip Code 21211 Was Decedent of Hispanic Origin? (Specify Yes or	USA 10g. Citizen of What Country? USA	an
LExaminated by Fun		1 XNever Married 2	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc 1 ☐ Yes 2 🎛 No Specify:	Black, White, etc. Specify: white	
ital Hygiene and unatural, or Itama 23a or 28a-1 ahow or other than "natural", or Itama 23a or 28a-1 ahow avent, itra Molical Examination at avent, itra Molical Examination at a Completed by Funeral Director	-	(Specify only highest grade completed) (Give life. Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation is kind of work done during most of working DO NOT use retired) maker	own home	
Mental Hy narked other natic avent,		17. Father's Name (First, Middle, Last) Claude Kincaid	18. Mother's Name (First, M Etta Rhode	es	
Health and tem 27 le m other traum		20a. Method of Disposition 20b. Place of Disp	ng Address (Street and Number or Rural Route Nul Place, Blasdell, NY position (Name of Date	umber, City or Town, State, Zip Code) 14219 20c. Location - City or Town, Sta	
Department of Health and Merital Important: If Item 27 Is marked o any Injury or other traumatic ave once. To Be	i	4 Donation 5 Other (Specify)	Crematory Inc. 8/18/2005 Rematory Inc. 8/18/2005 Remaind Address of Facility CAFA, Stephen D. Lohrma 8/17, Green Pastures Dri	Beltsville, MD	
hysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Bronchopneumonia Due to (or as a consequence of):		ory arrest, Appro	ximate al Between and Death
physicien and the burial-transit authority the burial-transit authority the burial-transit authority the burial-transit authority the burial-transit authority the burial examiner authori		Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pt completely tilled in by the tuneral director, page 2 should be deteched for use as it may be a suppleted by Physician/Med Medical Certification: To Be Completed by Physician/Med			⊒Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day	Year
en signed bould be dete		Part II. Other significant conditions contributing to death but not resulting in the Hip Fracture, Hypertensive Cardiovasco		Did tobacco use contribute to the caus	e of death?
cate has been s page 2 should Completed		Obstructive Pulmonary Disease, Chronic	V	Was an autopsy autopsy prior to completion death? as 2 □ No 1 □ Nyes 2 □ No	n of cause of
his certiti	Ш	25. Was case referred to medical examiner? 1 Nes 2 No Hospital: \text{\text{Inpatient}} 2 \text{\text{ER/Outpatient}}	26. Place of Death Check of the country of the co	nly one) Residence 6 Other (Specify)	
ath. rr: After t se tunera		27. Manner of Death 1 Natural 5 Pending 2 X Accident investigation 28a. Date of Injury (Month, Day Year) Injury 8-1-05	Work?	ribe how injury occurred ect fell	
urs after death. rel Director: After t led in by the tunera Certification:		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify) Nursing home	reet, factory, office 28f. Locati City o Midd1	on (Street and Number of Rural Route r Town, State) 1300 Windle e River, MD	ess Dr.
in 24 hound he Fune pletely till		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 1 Certifying Physician: To the best of my knowledge, dea and the best of my knowledge, dea and manner stated.	h occurred at the time, date and place, and due to exestigation, in my opinion, death occurred at the t	the cause(s) and manner as stated, me, date and place, and due to the ca	use(s)
To the comp		29b. Signature and title of certifier And Hillan and	29c. License number OCME	29d. Date signed (Month, Day, Ye AUGUST 17, 200	
1	-	30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		
State Registrar		31. Date filed (Month, Day, Year) ALIG 1 9 2005	NN STREET, BALTIMORE, 1	EMILEND, 21201	

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State of M		epartment of Health a Certificate of Death	and Mental Hy	Reg. N2 005	27188
			Decedent's Name (First, Middle, Last)			2. Date of De Month	aath Day Year	3. Time of Death
	Physicia /Medic	ai	ROSE MARY KASTEL			AUGUS	T 15 2005 4c. County of Dea	3:30 A M
	Examin	Ģ.	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	of Death	HARFORD	
	5		MARINER HEALTH OF BELAIR 5. Social Security Number 6. Sex 7. A	ge (In yrs. last birti	BELAIR hday) If Under 1 Year If Under			thplace (State or Foreign ountry)
	Funeral Director		218-01-7899 ¹□M ǯ\\F	85 Y	rrs. Months Days Hours	Min. (Month, Da		ryland
	p ,	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	l show	5	Maryland Baltimore		altimore County			1 ☐ Yes 2 ☑ No
	the N	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?
	3a or	i Di	4438 Forest View Avenue		21206		USA	
	deati	Funeral	11. Marital Status 12. Was Deceder Armed Force:	it Ever in U.S.	13. Was Decedent of Hispanic On If Yes, specify Cuban, Mexica	rigin? (Specify Yes or N In, Puerto Rican, etc.)	o- 14. Race - Am Black, Whi	
36	s after , or Ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🏖 🖔 Note: The second of the se		1 ☐ Yes 2 X D X No <i>Specify</i>			White
Ö	within 72 hours after death with the Maryland ene. ene. Than "natural; or flema 23a or 28a-f show the Modical Examiner must be notified at the Modical Examiner must be notified at	ed b	15. Decedent's Education		Decedent's Usual Occupation		16b. Kind of Business	s/Industry
215	hin 72 3. 9. "ne Wedie	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	r 5+)	(Give kind of work done during mo life. DO NOT use retired)	st of working		
2	filed wit Hygiene other the	Con	8 yrs. N/A		Assembler	ner's Name (First, Middle	Bendix Co).
and	be fit htal H od oth	Be	17. Father's Name (First, Middle, Last) Joseph Heisler			onica Bitte		
Maryland 21215-0036	s 1 and 2 should be fited within 72 ho the Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, the Macucal	6	19a. Informant's Name/Relationship (Type, Print)	19b	. Mailing Address (Street and Numb	ber or Rural Route Numb	per, City or Town, State,	Zip Code)
	and 2 sealth ar n 27 la		Rose A. Wolf (Daughter)	23	318 Howland Ct.	Forest Hill	, Md. 21050)
ē,	of Hear item		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from Sta	cemeter	Disposition (Name of ry, crematory or other place)	Date	20c. Location - City o	r Town, State
Ë	Pages ment of I ant: If its ury or o		'4 □Donation 5 □Other (Specify)	Garde	ns of Faith Cem	-	Baltimore,	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee	eral Home	7401 Belaim Baltimore,			
			23a. Part1. Enter the disease or complications that caus shock, or heart failure. List only one cause on each	s cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death		
Immediate Cause (Final disease or condition a. ACUTE MYCCATAL T							ction	Few Hours
	/Medical Examiner		resulting in death) Due to (or	as a consequence	A Contraction	111011		\ - 1 11e >
		e e	Sequentially list conditions, if any, leading to him sofiate.	as a consequence	of):			1
di	uted d ansit	min	if any, leading to firm adjate cause. Enter Underlying Cause (Disease or injury that initiated events c.					
0,	cate be executed physicien and the burial-transit	dical Examiner	resulting in death) Last Due to (or	as a consequence	of):			
58760,	cate b	dica	d:					
_			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome the pregnant of the		0.75		23d. Date of d	,
. Box	requires that the death certifi been signed by the attending should be detached for use as	Physician/M	in the neet 12 months?	2 ☐ Fetal death t at time of death	n 3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
P.0	at the I by th stache	Phys	9 Unknown		in the underhing government in Par	23e Did	tobacco use contribute	to the cause of death?
	requires that the leen signed by th hould be detache	by	Part II. Other significant conditions contributing to deat	- LIA D	. I mana yay	*an		Probably 4 Unknown
Ö	v requ been should	etec	CHYONIC CHS IN ME	16-4-16	XI FIN CHIEL TY	24a. Wa		autopsy findings available
Rec	e lav has je 2	Completed				aut per 1 ☐ Yes	formed? death?	
ta	ician: Th certificate rector, pag	a	25. Was case referred to medical		26. Pla	ce of Death Check onl		
Ţ	d is	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inp	atient 2 ☐ ER/Ot			sidence 6 Other (Sp	necify)
0 [fte en		1 Matural 5 Fending		Time of 28c. Injury at 1 ☐ Yes 2 [e how injury occurred	
Division of Vital Records,	Attending ir death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of determined	Injury - At home, fo	arm, street, factory, office	28f. Location	(Street and Number or	Rural Route Number,
Di∨	after after Dirac d in by	Certification:	4 Homicide determined building	, etc. (Specify)		City or 1	own, State)	
	To the Hospital or Attendir within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Physician: To the b	is of examination ar	e, death occurred at the time, date nd/or investigation, in my opinion, d	and place, and due to the eath occurred at the time	e cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier		29c. License numbe	r	29d. Date signed (Mo	nth, Day, Year)
	. , , , ,		Mand Ml	/	D19.57	83	August	15,2005
			30. Name and address of person who completed cause	of death (Item 23a)	(Type, Print) & Le	in Stre	et; Abe	erdeen
	l a		31. Date filed (Month, Day, Year) 32. Reg	nistrar's Signature	MP	· M	arxland	21001
	St Regist	ate trar	AUG 1 9 2005	Care . A	Amost D			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. 📢. 🗍 2. Date of Death 1. Decedent's Name (First, Middle, Last) Q Year Month Day **Physician** Joseph Vincent Kroner, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ROSE 13 464 INP If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min. Days Hours 1**X** M 2□ F Months Director 70 2/11/1935 Maryland 217-30-3102 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other then "neturel", or iteme 23e or 28a-f show treumatic event, the Madical Examiner must be inclifted at 1 ☐Yes 2 No Director Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21085 1036 Erwin Drive S. Α. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. I importent: If tiem 27 is marked other then "neturel", or Iten eny Injury or other treumatic event Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County 10 Public School Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alfred King Anna Mary Serio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joppa, Maryland 21085
Date 20c. Location - City of 1036 Erwin Drive Frances May Kroner (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8/20 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licenses PA Essex, Maryland 21221 23a. Part1. Enter the disease, or commerciations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 57619 34 Prysician /Medical Due to (or as a consequence of): Examiner 5, Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to for as a consequence of: Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medicai for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy mod 10/13/5 MID 2 🗆 No 2 1 No 1 Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 1 Yes 2 🗌 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this To the Hospitel or Attending Pr within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier MU 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) scandla-W. 21 CAMS 1000 31. Date filed (Month, Day, Year)
AUG 1 32. Register's Signature State 2005 Registrar Sporte

State of Maryland / Department of Health and Mental Hygiene Registrar Amend item #19a PER FH C847 9766965 SH Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) August 17, 2005 **Physician** Laslett 8:05 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Gilchrist Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. July 29, 1932 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖫 F Maryland 73 213-30-6800 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10a State 10b Counts 1 ☐ Yes 2 X No MD Baltimore Lutherville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r then "natural", or Items 23s or the Medical Examiner must be 21093 U.S.A. 11751 Greenspring Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White ۾ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edna Shanklin Houck Clarence 19a. Informant's Name/Relationship (Type, Print)
Raymond W. Haslett, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If itam 27 Is
eny injury or other trau Sr.-husband 11751 Greenspring Ave., Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State 8/20/05 Parkwood Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LIVER Stage. **Physician** months d /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1☐Live birth 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mellitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number and 30. Name and address of person who concleted cause of tenh (Item 23a) (Type, Print) Balto and GBINC N. Charles St. 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 9 2005 Registra

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amend item#21, perFH, C846, 8/19/05 11 State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Manorca Woodbridge Valle 01 OnSVI If Under 24 Hrs. at more If Under 1 Year 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 245-54-6849 Usual Residence of Decedent 1□M 20 F Director North Carolina filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits wat be notified at 1 Yes 2 □ No Funeral Director nore Varyland 28e-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ 121 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after des ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "neturel", or Items ury or other traumatic event, it is the fired in all my or other traumatic event, it is the fired. 11. Marital Status 1 ☐ Yes 2 X No ff Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Be Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

\[\lambda \lambda \cdot \lambda \cdot \lambda \cdot \lambda \cdot \lambda \cdot \lambda \cdot \c 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 22 `4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Joseph L. Russ perDVR 22. Name and Address of Each 100 Seph L. Russ perDVR 2222 W. North Import any inj once. WiNorth Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shops, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) POC ARCINOMA **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physiclan/MedIcal the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 DEctopic pregnancy signed by the atte Month Day Year 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ∏Yes 2 ∏No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 2 🗆 No 1 ☐ Yes 1 Yes of Vital After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No မှ 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Naturaf 5 ☐ Pending investigation Japiter ...
4 hours after dea...
-rel Director: Afr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) D577 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL PILLE #603 BALTIMUNE MP 21228 5602 BACTIMORE LEUNARD RICHARDSON 31. Date filed (Month, Day, Year) 32. Registear's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 o'6Z **Physician** 0 Ρ. Francis McKenna Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Roseda ,to mo HO59 STua If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year) Days Hours XIXIM 2□ F 213-10-8238 86 Dec. 29, 1918 Maryland Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23e or 28e-f shov traumatic evant. It e Medical Evaral at must be motified at MD Baltimore 1 Yes 2 No Director Essex 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 417 Margaret Ave. 21221 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) American Can Hygiene. Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I pe Lena Salkowski Francis P. McKenna Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If itam 27 is any injury or other trau Health a 4407 Dowery Lane Belcamp MD 21017 Rose MArie Strine /niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of XX Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD PArkwoodCemetery 8/22/05 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ConnellyFuneralHomeofEssex nni 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or cor shock, or heart failure. List only plicetions that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** newmon, o /Medical Due to (or as a consequence of): Examiner D Sequentially list conditions, if any, leading to immediate cause. Enter Under ying Cause (Disease or injury Due to (or as a consequence of): Examine executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 that the death certificate be Physician/Medical as the t IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq 1 Z Yes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law has autopsy performed certificate 1∐ Yes 2/ No 1 Yes 2□ No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 2 1 / Inpatient 2 ER/Outpatient 3 DOA this uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 2 □ No death. 1 Yes after death in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 24 hours a To tha Funaral D Hospitel Medical

State

(Check only one)

29b. Signature and title of certifier

s of erson who coullete

29c. License number

29d. Date signed (Month, Day, Year)

use of death (Item 2) (Type, Print)

ware Drive Baltimal 9000 Pan Klin Kanlun eung 32. Registrar's Signature

Registra DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylar		artment rtificate				lental Hy	giene Reg. No.	005	27193	
	Physici		Decedent's Name (First, Middle Sara	e, Last)	D.		Me	ett]	ρ.		2. Date of Dea Month AUGUST	ath Day 16	2005	3. Time of Death 9:34PM M	
	/Medic Examir		4a. Fecility Name (If not institution	a, aive street and num			,		Location o		nagaso		County of Dea		
	Examir	ier	Genisis Elder		,				na Pa					Arundel	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	th V Voor)	Q Ri		
	Director		216-09-5264	1□M 2ÅF	92	Yrs.	Months	Days	Hours	Min.	June23,	, '191	9. Birthplace (State or Foreign Country) Pennsylvania		
	pug *		Usuel Residence of Decedent 10a. State 10b. County		10c Ci	ity, Town or Lo	cation							10d. Inside City Limits	
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or Items 23e or 28e-f show injury or other traumatic event. The Medical Exam art must be multified at finjury or other traumatic.	tor		Arundel		adena								1 □ Yes 2 □ No	
	th the	Funeral Director	10e. Street and Number				10f. Zip	Code				_	en of What C	ountry?	
	23a	ai	1095 Fitz Ct.				2'	1122				USA			
	er deg	nue	11. Marital Status	12. Was Dece Armed For	dent Ever in U ces?	J.S. 13.	Was Decede If Yes, speci	ent of Hi rty Cubar	spanic Ori n, Mexican	gin? (Spe 1, Puerto	cify Yes or No Rican, etc.)	- 14	4. Race - Am Black, Whi		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	ied 1 □ Yes If Yes, Giv Year or Da	Θ		1 ☐ Yes 2	2 □XNo	Specify:			5	Specify:	white	
21215-0036	2 hou	led	15. Deceden	t's Education		16a. Dece	dent's Usual	I Occupa	ition			16b. Kind	d of Business	/Industry	
215	thin 7.	ple	(Specify only higher Elementary/Secondary (0-12)	College (1	-4or 5+)		dent's Usual kind of worl DO NOT use	k done d e retired,	uring mosi)	t of worki	ng				
7	filed within Hygiene. other than "	Completed	12			wai	tress						staura	nt	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumetic event, the Ms	Be	17. Father's Name (First, Middle, Charles	Last) Bequeã	ath					or's Name Mart	(First, Middle, .ha	Maiden S		Pea	
ary	should nd Men marke umaric	To	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a	nd Numbe	er or Rura	l Route Numbe	er, City or	Town, State,	Zip Code)	
	and 2 lealth a m 27 is		Robbin Mettle	son					Ct. P	asad	lena MD	2112	2		
Baltimore,	of He of He of He		20a. Method of Disposition 1	3 □Removal from S	1 .	Place of Dispo cemetery, crei	sition (Nam natory or oti	e of ther place	9)	D	ate	20c. Loc	ation - City or	Town, State	
Ti.	ment tant: jury c		'4 □ Donation 5 □ Other (S	pecify)		oudon P					st 19,2	005	Baltim	ore MD	
Bal	permit. Pages Department of Important: If i any Injury or once.		22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena, MD 21122 Approximate Interval Between shock, or heart failure. List only one cause of each line.												
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that ca	aused the dea									Approximate Interval Between	
4	Physician		Immediate Cause (Final disease or condition	Ac	War	2000	rl	6	orr	101	stia			Onset and Death	
	/Medical Examiner		disease or condition resulting in death) a											() cars	
	Cxammer	Ļ	S quentially list conditions.	b											
,	ted	nine	S opentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence ot):									
_^	al-tran	Examiner	that initiated events resulting in death) Last	c	or as a consec	quence of):									
8760,	cate be executed physician and the burial-transit	dicai E		d					-,						
9	rtifical ng phy as th	Medi	IE EENALE.												
Вох	ath certific attending p for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	come of pregn	ancy al death 3[Ectopic pre	gnancy				23	d. Date of de	livery Day Year	
.O.	the di	Physician/Med	1 Yes 2 No	4□Pregna 9□Unkno	ant at time of o wn	death 5	Other (spe	ecify)			<u> </u>		MOUTH	Day	
Q	res that the		Part If. Dther significant condition	ons contributing to de	ath but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco use	e contribute to	the cause of death?	
rds	quires in sign	q pa	Cerebrov	asculo	0.0	accio	den	1			1 🗆 Y	/es 2□	No 3□P	robably 4 Unknown	
00	aw requir as been si 2 should	piete									24a. Was		24b. Were a	topsy findings available	
Vital Records,	The lay	Completed by									autop perfor	rmed7	prior to death? 1 \(\sum \) Yes	comptetion of cause of	
'ital	ysicien: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	_			
of V		2	1 ☐ Yes 2 ☑ No			ER/Outpatier		_	4 Prou	-	ne 5□ Resid			cify)	
	ding P	ion:	27. Manner of Death 1 D Natural 5 □ Pendin		f Injury h, Day Year)	28b. Time of Injury	M 28	Bc. Injury Work			28d. Describe h	now injury	occurred		
Division	or Attendi after death. Director: A in by the fu	icat	2 Accident investig	not be	of Injury - At h	ome, farm, str			′es 2 □ f		P8f Location /9	Street and	Number or R	ural Route Number.	
Div	al or A s after il Dire	Certification;	4 Homicide determ	buildin	g, etc. (Speci	(fy)	cot, ractory,	Office			City or Tow		TOTAL OF THE	stat troute trainber,	
	To the Hospital or Attending Phwithn 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the Examiner: On the ba and mann	sis of examina	owledge, death ation and/or in	n occurred a vestigation,	it the tim in my op	e, date and inion, deat	d place, a	and due to the dead at the time, d	cause(s) a date and p	nd manner as lace, and due	s stated. to the cause(s)	
L.	To th withir To th comp	Me	29b. Signature and title of certifie		1 1	- 14	29c.	License	number			29d. Date	signed (Mont	h, Day, Year)	
									50.	72	5	8-	17-	2005	
	3		30. Name and address of person	who completed cause	of death (Item	116h		4.	11/	1.11	ersul	110	MIS	21108	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signa	ature	VIII)	100	7	1100	5070	re			
	Registi		AUG 1	9 2005	PARILE 2	A. A	South .	Ø							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year MCGREEVY **Physician** HUGSH WILLIAM 7-55 AM 146 200 r /Medical 4a. Facility Name (If not institution, give street and number) BALTIMORE 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE EXTENDED CARE CENTER If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 218-18-0558 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 la marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinant han notified at BALTIMORE 1 es 2 No Director MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21206 HVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 If Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Helen 19a. Informant's Name/Relationship (Type, Print) 191. Mailing Address (Street and Number 🛪 Rural Route Number, City or Town, State, Zip Code) Moulsby BelAir Date 20b. Place of Disposition (Name of cemetery, crematory profiler place)

EVANS FUNERAL CHART - 8 20a. Method of Disposition 20c. Location - City or Town. State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) -05 21. Signature of Funeral Service License 22. Name and Address of Facility YOLKRD, TIMONIUM MD 21093 mulech YEACEFUL ALTERNATIVES FUNERAL-CKEMATIONCTR nolle 23a. Part1. Enter the disease, o shock, or heart failure. Lis on, that aused the 14 th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death complications Immediate Cause (Final disease or condition resulting in death) DEMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 ☐ Yes 2 No cate has been sig , page 2 should b STROKE 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 No 1 Yes 2. No 1 TYes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 3□ DOA ē uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 X Natural 5 Pendina 1 □ Yes 2 □ No investigation 2 Accident the Funeral Director: npletely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide vithin 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 056508 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 2/2/0 LOCH RAVEN 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name, (First, Middle, Last) 2. Date of Death Month 12:30P. **Physician** enney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number BALTIMORE ML T MORE
r If Under 24 Hrs. 1 Year 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 □ F Months Days Hours Min 291-50-379 Yrs. Director Usual Residence of Decede permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, the Medicul Examination. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Completed by Funeral Director TIMOR SALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 Married 1 Never Married 1□ Yes 20 No Specify 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Informant's Name/Relationship (Type, Print) City or Town, State, Zip Code) OH 44907 ansheld 20b. Place of Disposition (Vame of cemetery, cremathry of ditter) 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20c. Location - City or Town, State dress of Facility BACTIMORE, MO 21234. EVANSFUNERAL CHAPEL, 8800 HARFORD RD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit pertension Division of Vital Records, P.O. Box 68760, IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1□ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 2 No 1 🗌 Yes Medical Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier completed cause of deat (Item 23a) (Type

State Registrar

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9 2005

32. Registrar's Signature

			State of Maryland / Department			0000		
			1 - State Registrar Ce 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg 2. Date of Death	I. No.2 [] [] 5	7 1 9 6	
	Physicia		Norman Howard McDevitt, Sr.		Month 08/15/	Day Year	5:00 P ^M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	00/13/	4c. County of Death	J.00 I	
I			7817 E. Shore Road	Pasadena		Anne Arundel		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 212-28-2020 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y 0 2 / 2 4 / 1	(ear) 9. Birthplac Country	ce (State or Foreign MD	
			Usual Residence of Decedent		02/24/1	1930	1110	
	anylan ehow	_	10a. State 10b. County 10c. City, Town or Lo			10d.	. Inside City Limits 1 ☐ Yes 2 ☑ No	
	he Ma	ecto	.MD Anne Arundel Pasade	na 10f. Zip Code	100	. Citizen of What Country		
	with Ba or	10	7817 E. Shore Road	21122	109	U.S.A.	•	
	death	era		Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American		
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Š	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28s-f ehow ent, the Medical Examinat must be notified at	d b	3 Wildowed 4 Divorced Year or Dates: 1953		1.00	WIII		
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Mar	C1 = 00			ng Address (Street and Number or Rura E. Shore Road				
	Health Thealth tom 27 other to		20a. Method of Disposition 20b. Place of Dispo			c. Location - City or Town		
ē	Pages nent of snt: If It ary or o			ven Mem Pk 08/1	8/05	elen Burni	e, MD	
Baltimore,	permit. Pages Department of t Importent: If Ite any injury or of			2. Name and Address of Facility G .				
m —	99559		109/100	69 Riviera Driv			21122	
ı,			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart fallure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	t, Al	pproximate iterval Between inset and Death	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	1 Cancer				
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		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
×	cuted nd ransit	Examiner	cause, Enter Underlying Cause (Cleases or injury that initiated events c.					
760,	ate be executed thysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):					
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<u>Ч</u>	at the by th	Phys	9 ☐ Unknown 9☐ Unknown					
S,	50 0	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	cco use contribute to the c	ly 4 □Unknown	
Records,	w requir been si should	Completed			24a. Was an			
Rec	he law e has	ldmo			autopsy performe	d? death?	letion of cause of	
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	Physicie this cerr al direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Other	-	ce 6 □Other (Specify)		
Division of	Attending Physicien: ir death. ector: Atter this certific by the funeral director,		27. Manper of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Injury	Work?	28d. Describe how	injury occurred		
Sio	ttendi death. ctor: A / the fu	icati	2 Accident investigation	M 1 Yes 2 No	286 Location /Strac	et and Number or Rural R	lauta Alumbar	
$\frac{1}{2}$	l or Attence after death Director: I in by the	Certification:	determined determined determined determined determined determined	теет, тастогу, опісе	City or Town, S	State)	oute Number,	
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in					
	To the Ho within 24 i To the Fu completely	Med	one) and manner stated. 29b. Signature and tipa of certifier	29c. License number	29d	I. Date signed (Month, Da	y, Year)	
	- >- 0		In / lung ms	04715/	A = A	fugust 16	, 200)	
	5+1		30. Name and address of person who completed cause (1 Jath (Item 23a) (Type	Print) NCLOON NO GLET	~Burnt	Highest 16 E, MD 24	061	
	Sta R egisti		31. Date filed (Month, Day, Year) AUG 1 9 2005 32. Registrar's Signature	rade				

2. Date of Death

Month

	Physician
	/Medical
	Examiner
-	

Funeral Director

MAINJOHN

PHYSICIAN

TO

KNOWN

NAME

21215-003

Maryland

with the Maryland in than "natural", or Items 23a or 28e-f ehow The Medical Exprimer must be notified at permit. Pages 1 and 2 : Department of Health ar Importent: if item 27 Is any injury or other treu once.

Physician /Medical Examiner

The law requires that the death certificate be executed physician and s the burial-transit attending peeu To the Hospitel or Attending Physicien: To the Funeral Director: After th completely filled in by the funeral

Division of Vital Records, P.O. Box 68760.

2:55 P M AUGUST 16, 2005 Franklin Main 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death VA MARYLAND HEALTH CARE SYSTEM PERRY CECIL POINT If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) M 2□ F Months Days Hours 1927 Maryland 26, 216-24-8116 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√2 No Maryland Baltimore Timonium Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 310 Presway Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Gyes 2 No If Yes, Give Year or Dates: 1946-48 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled None 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Main Mabel Webner Charles 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Presway Rd., Timonium, MD 21093 Florence Monaghan (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 8/19/ 05 Baltimore, Maryland Loudon Park Cemetery 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UNKNOWN DEHYDRATION disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown CHRONIC SCHIZOPHRENIA, HYPERTENSION, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an NEUROGENIC BLADDER, RECURRENT URINARY TRACT INFECTION autopsy performed 2 No 1 ☐ Yes 2 XNo 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending M 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MITEL 151094-1 August 16, 2005 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Melecia Santos, M.D., VA Maryland Health Care System, Perry Point, MD 21902 31. Date filed (Month. Dav. Year) 32. Remistrar's Signature State

Registrar DHMH 17 Rev 1/2001

within 24 hours a

AUG 1 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 14 **Physician** Month MANSOH JOSHUALYN 00:35 M 05 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MERCY MEDICAL CENTER BALTIMORE CIT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F 240-13-1511 45 Director 07-11-1960 North Carolina Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, it a Modical Exactinar result by ruilified at 1**XX**Yes 2 □ No MD NA **Baltimore** Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 E. Lanvale Street 21213 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 222No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Claudie Lee Kimber Ruby Jane Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4612 Hampnett Avenue Baltimore, MD 21214 Selvita O. Robinson/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 08-19-05 Lansdowne, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street Baltimore, MD 21217 Wylle Funeral Home 638 N. Gilmor St. Parl Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BURAST CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at I be detached fo 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No 9 Unknown 9 SUnknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? 1 🗌 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel 6 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) , MD RESIDENT PHYSICIAN

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

ORIGINAL

BALTIMORE

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 9 2005

301 ST. PAUL ST. PL

31. Date filed (Month, Day, Year)

D32365

		-	For State Registrar	State of Maryland	•	rtment of I		and Mental Hy	ygiene Reg. N2 0 0 5	27199
	Physicia	an	1. Decedent's Name (First, Middle, Last)	110/05		-		2. Date of D Month	Day Year	_ 1 20 411
À.	/Medic Examin		4a. Fecility Name (If not institution, give s	1	4000	4b. City, Town,	or Location o	f Death	4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Sex 218-28-9244	7. Age Jin yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. 8. Date of B Min. (Month, D 09-21-1	irth 9. Bi	rthplace (State or Foreign country) ryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	Maryl B-f ehc	tor	MD NA		Balt	imore				1 X Yes 2 □ No
	vith the	Director	10e. Street and Number			10f. Zip Code	1000		10g. Citizen of What C	
	ns 23e	Funerai	5 Annadale Ct.	12. Was Decedent Ever in U.S	i. 13. W		1208 Hispanic Oriç	gin? (Specify Yes or N , Puerto Rican, etc.)	US/ lo- 14. Race - Am	erican Indian,
036	al', or Iter	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates:		Yes, specify Cub		, Puerto Rican, etc.)	Black, Wh	Black
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show apply injury or other traumatic event, the Midral Esaninar must be nutilized at once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e com <i>pleted)</i> College (1-4or 5+)	(Give k life. D	ent's Usual Occu ind of work done O NOT use retire	during most ed)	of working	16b, Kind of Busines	
Q 23	filed with Hygiene. other than	o Co	12. 17. Father's Name (First, Middle, Last)			teel Work	1	r's Name (First, Midde	Bethlehem le, Maiden Sumame)	Steel
/lan	vuid be Mental arked o	To Be	Joseph McDouglas				Eas	ster Lily McI	ouglas	
	and 2 should Balth and Men n 27 le marke ler traumatic		19a. Informant's Name/Relationship (Ty Lillian Kumar/ Sister	pe, Print)				Galloway, NJ	ber, City or Town, State, 08205	Zip Code)
Baltimore,	Pages 1 and the part: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	temoval from State		ition (Name of atory or other pla		Date 08-18-05	20c. Location - City of Lansdowne, MI	
Balti	permit. I Departm Importa eny inju		21. Signature of Funeral Service License		22.	Name and Addr		•	nor St. Baltim	
* 1	4		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death	. Do not ente	the mode of dy	ing, such as	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	pance	sh't	CAK	2000	oma		Onset and Death
	Examiner		On a section of the second section of	Due to (or as a consequ	erice or):					
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o,	icate be executed physicien and s the burial-transit	Examiner		Due to (or as a consequ	ence of);					
8760,	cate be physicie the bu	dicai		d						1:
Box 6	auth certifi attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3 🗌	Ectopic pregnand Other (specify)	су		23d. Date of d Month	elivery Day Year
P.O.	t the by th tache	hysi	9 Unknown	9□ Unknown				99 91	1	1. the arms of death?
		by	Part II. Other significant conditions con	ntributing to death but not resu	iting in the un	derlying cause g	iven in Part I		tobacco use contribute]Yes 2□No 3□!	Probably 4 Hinknown
Vital Records,	e law requires has been sign ge 2 should be	Completed						24a. We	lopsy prior to	autopsy findings available completion of cause of
al B	Thate at a							1 □ Yes		es 2 No
	S S	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 I	R/Outpatient	3 DOA 0	thor	of Death (Check only irsing Home 5 Re	vone) sidence 6 □Other (Sp	pecify)
on of	ding Phy h. After thi funeral	ation: T	27. Manne of Death 1 PNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		ury at ork?] Yes 2 []		e how injury occurred	
Division	or Attanding after death. Director: After	Certifica	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office)		(Street and Number or i own, State)	Rural Route Number,
	Hospita 4 hours Funerel	edical C		sician: To the best of my know iner: On the basis of examinat and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier				nse number		29d. Date signed (Mo	nth, Day, Year)
	Λ		· Guy	2011	00-1-7	P1.	187	2 stran	Hyush 1	8, 2005
	3		30. Name and address of person who co	ompleted cause of death (Item	(156)	Re	s de	stran	Mo	
17	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 1 9	32. Registrar's Signat	ure	Lack 2				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2005 Mary Ann Murphy August 15, 9:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 410 Russell Avenue, Apartment 416 Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Funeral Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🕅 F 578-28-1050 86 26, Director 1919 New York Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Exerting rust be notified at Maryland Montgomery Gaithersburg 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 Russell Avenue, Apartment 416 20878 United States Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: þ Specify: White 3 X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within : Health and Mental Hygiene. em 27 Is markad other than ". Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Murray Georgetta Tole ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Leonard M. Murphy, Jr. / Son 13700 Turkey Foot Road, North Potomac, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State August 19, 2005 Silver Spring, Maryland Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2808 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Cardiac Arrhythmia Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Myocardial Ischemia Minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine law requires that the death certificate be executed physician and s the burial-transit Coronary Artery Disease Years that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No for Month Year 4 Pregnant at time of death 5 Other (specify) P.O. | the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 99 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Insulin Dependent Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension, Hyperlipidemia 24a. Was an certificate has 1 ☐ Yes 2**X** No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 M Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ပ 1 X Yes 2 ☐ No 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral L 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 296 Signature and title of certifier 041794 August 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Priscilla Callahan-Lyon M.D. 911 Russell Ayenue, Gaithersburg Maryland 20879-3266 Gonda) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 9 2005 DEPENDED. Registrar

			1 - For State Registrar	State of Ma	aryland				ealth a Death	and M	-	giene Reg. No	200	5	272	n I
			Decedent's Name (First, Middle, Last,)							2. Date of De	ath		<u>U</u>	3. Time of I	Death
	Physici /Medio		Eileen Mary Mei	rcer							Month Augus	t 17	, 20ŏ	ear 5	3:07	A M
1	Examir		4a. Facility Name (If not institution, give				4b. City	, Town, or	Location o	of Death		40	. County of	Death		
			6005 Cheshire Dri 5. Social Security Number 6. Sec		e (In yrs. la:	nt histoday)		thesd	a If Under 2	24 Hrs	O Date of Di-		Montg			
95	Funeral Director			M 2∭2 F	88	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Sept • 25	y, Year,	916	Coun	lace (State or ntry) 1ada	' Foreign
	p.		Usual Residence of Decedent								ьере . 1.5	,	7.10			
	ehow	2	10a. State 10b. County			Town or Lo	cation							10	0d. Inside City 1 ☐ Yes	
	28a-f	Director	Maryland Montgome	ry	вет	hesda	106 7	p Code				10a C	tings of late.			2 140
	Sa or		6005 Cheshire Driv	10				0814					tizen of Wha		,	
	death ms 2:	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.		Vas Dece	dent of His	spanic Orig	gin? (Spe	cify Yes or No		ted St	Americ	an Indian,	
9	within 72 hours after death with the Maryland ene. than "naturel", or items 23s or 28s-f ehow its Madical Examinar mail be notified at	/Fu	1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 Yes 2 24 If Yes, Give	No		Yes, spe ☐ Yes		n, Mexican Specify:	i, Puerto F	Rican, etc.)		Black,	White, 6	etc.	
00	hours	d by	3 Widowed 4 Divorced	Year or Dates:									Specify:		nite	
15	in 72	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		16a. Deced (Give	kind of wo	ial Occupa ork done d ise retired)	urina most	t of workin	g	16b. K	and of Busin	ess/Ind	lustry	
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yla	Ment Ment mrkec	2	John Knight								ed Chan					
Maryland 21215-0036	12 sh h and 7 ie m traum		19a. Informant's Name/Relationship (Ty Mary-Margaret Mer		tor						Route Numbe					
ē,	1 and Healt tem 2		20a. Method of Disposition	cer/baugn	20h Pla	ce of Disnos	sition (Na	me of			ethesda		ary⊥aı ocation - Cit		20814 wn. State	
MO	Pages ent of nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Gate	netery, cren e of F	ieave	other place n	?) A	ugusi 005	20,				ng, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-1 show eny figury or other traumatic event, the Medical Examination must be notified at ance.		21. Signature of Funeral Service Licers	99		Cemete	Name a	nd Address	s of Facility	Robe	ert A.	Pum	phrev	Fur	neral h	iome/
<u> </u>	88 = 8		13ins	bery.	M008	$03 \mid \frac{B}{B} \mid$	etnes	sda,	nevy Maryl	and	20814	-350	1/ Wis	scon	ısin Av	/enue
П			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused ne cause on each lin	the death. ne.	Do not ente	er the mod	de of dying	, such as o	cardiac or	respiratory ar	rest,			Approximate Interval Between	reen
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	cuted nd transit	Examiner	that initiated events	:												
50,	cate be executed physicien and the burial-transit	Ex	resulting in death) Last	Due to (or as	a conseque	nce of):										
8760,	physic	dlcal		1												
Box 6	death certific e ettending p id for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome							Av.		23d. Date of	delino	01	
	that the death ted by the etter deteched for u	by Physician/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic p Other (sp						Month			9аг
P.O.	at the by the	hys	9 Unknown	9□ Unknown												
	8 P. B	by	Part II. Other significant conditions con Hypertension	tributing to death bu	t not resulti	ing in the un	derlying o	ause give	n in Part I.						e cause of dea	
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Rec	e la has	dm									24a. Was autop		24b. Wer prior deat	e autop to com h?	sy findings av	vailable use of
ta		0	25. Was case referred to medical						OC Diese	of Dooth	1 ☐ Yes	2€ No	1 🗆	Yes 2	2□ No	
<u> </u>	ysician: is certific director,	To B	examiner?	lospital:	nt 2□EF	P/Outpatient	3□ DC	Other			e 5X Resid		6 ∏Other (Specify)	
0 0	ng Ph fter th neral	ü	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 2	8b. Time of Injury	2	8c. Injury Work			Bd. Describe h			, poo., y		
Sio	Attending Physician: r death. ector: After this certific by the funeral director,	catl	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗆 Y	es 2 □ N	lo						
Division of Vital Records,	in the second	Certification:	4 Homicide determined	28e. Place of Inju building, etc	iry - At hom :. (Specify)	e, farm, stre	et, factor	y, office		28	3f. Location (S City or Tow	treet an m, State	d Number o	r Rural	Route Number	⊖ <i>r</i> ,
_	Hospital 24 hours a Funaral (tely filled		29a. Certifier 1 Certifying Phys	ician: To the best of	of my knowle	edge, death	occurred	at the time	a. date and	place ar	nd due to the o	ause(s)	and manne	r as sta	hed	
	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the	Medical	(Check only 2 Medical Examinations)	ner: On the basis of and manner sta	examination	n and/or inv	estigation	, in my opi	nion, death	h occurred	d at the time, o	date and	place, and	due to	the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	P. 11.			290	c. License	number		2	29d. Dat	e signed (M	lonth, D	lay, Year)	
	1/	7	, oran	um	M	7		D005	1779		A	Augu	st 17	, 20)05	
1"	10		30. Name and address of person the co William J. Cullen					Soule.	ward	#30	0, Rock	- T - 1	10 M	70.5.1	and or	1852
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra			LVE I	Oute	· alu,	,, 50	· , KOCE	~~	ie, Pla	3 L Y I	.anu 20	,032
	Registr	_	AUC 1	0 2000	P.	g.	A									

DHMH 17 Rev 1/2001

Registrar

4b. City, Town, or Location of Death

Towson

ELIZABETH

JOAN

4a. Facility Name (If not institution, give street and number)

St Joseph Hospital

NEWI ON

August 15, 2005

4c. County of Death

Baltimore

5:10AM

Physician /Medical Examiner

Funeral

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician been signed by has After

If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) January 18, 1922 9. Birthplace (State or Foreign Days Hours 1□M AT Yrs. 216-16-6010 Director Kentúcky Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, it e Madical Examinar must be notified at 1 □ Yes 2 □ No Funeral Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 Walther Blvd 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXINo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify Specify: White þ XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other t any injury or other traumatic event, II 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Louis Hile Olivia Drescher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, James H Storrs Son 1641 Isabella Court Millersville Maryland 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State GreenMount Cemetery 8/17/05 Baltimore, Maryland □Donation 5 □Other (Specify) ignature of Funeral Service/Licensele 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one is use on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** resp: ratory /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Diverticular Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) imn. D5864 -00 16,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registra

Monics

31. Date filed (Month, Day, Year)

8800

ORIGINAL

Bustosand

Walther

32. Registrar's Signature

DHMH 17 Rev 1/2001

AUGUST 15, 2005

LORETTA PETRACCA

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Richard Nelson Phelps 18, 2005 5:45 A. August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Broadmead Cockeysville Baltimore County If Under 1 Year | If Under 24 Hrs.
Months Days Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) Months 1⊠M 2□F 88 213-28-0324 April 10,1917 Baltimore, ID. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes 2 ☒ No Director Maryland Baltimore County Cockeysville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 13801 York Road 21030 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1ሺ]Yes 2 □ No If Yes, Give Year or Dates: ₩•₩•II 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ™ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Flementary/Secondary (0-12) 12 Assistant Gen. Mgr. MD. State Falir/ State of Maryland 04 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Morgan Phelps Florence McLean ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jane P. Hoyt (Cousin) 27 Tenbury Road Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 8/20/2005 Timonium, Maryland 1 Burial 2 Cremation 3 Removal from State Dulaney Valley Mem.Gard. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr. P.A 2325 York Road Timonium, Maryland 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCUL Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Orderfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? þ 1 Yes 2 12No 3 Probably 4 Unknown

Pnysician /Medical **Examiner**

Funeral

Director

ed other than "natural", or Items 23a or 28a-f sh avent, the Medical Examinal must be nutified

d 2 should be filed within 7 h and Mental Hygiene.
7 Is marked othar than "r

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is

Baltimore, Maryland 21215-0036

burial-transit

death.

of Vital Records,

Box 68760 P.0. Division 24 hours a

To the Within 2

29a, Certifier

State Registrar

Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 1 No 5 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 2 1 No 2 1 🔲 Yes 6 ☐Other (Specify) 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Whatural 5 ☐ Pending investigation 1 TYes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 1 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item per in 848 10-4-05 vt

Amend item II per inf 8848 10-7-05 vt Pepartment of Health and Certificate of Death 1 - For State Registrar Reg. No. [] [] 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Phillips Sylvia /Medical 5:00p4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arundel ANNE 300 Vernon Glen Burnie Ave If Under 1 Year If Under 24 Houndary Days Hours Mi 5. SQ140444098 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 ☐ F Months 33 Director 24 **England** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int If itam 27 Is marked othar than "natural", or Items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in of Health and Mental Hygiene.
If itam 27 Is marked other then "natural", or Items 23e or 28e-f show or other traumetic avant, it a Modical Experiment must be not liked at 1 ☐ Yes 2☐No **Funeral Director** MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Vernon Ave **England** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 No f Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Be Completed by Specify: 3 Widowed 4 Nivorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Server Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Unknown ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy O. Phillips / Son 300 Vernon Ave, Glen Burnie, MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. 21. Sign turk i Fun russervi Greensee Glen Haven Cemetery 8-20-05 Glen Burnie, MD 22. Name and Address of Facility Fink Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Arthisalholi Cardiovanula /Medical Due to (or as a consequence of): **Examiner** Diahele Sequentially list conditions, if any, leading to limite diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of). To tha Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): of Vital Records, P.O. Box 68760, attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 4 14 2005 D50108 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) bur Buran MO 21061 7945 Oakwood Road, July 200 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 9 2005 Registrar

Sherry Podles Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. unpend item#23a 27, 28a-f. perME G846,8/24/05 TT State of Maryland / Department of Health and Mental Hygiene 05-05452 NJM 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Podles 1514 Sherry August 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Dundalk 704 Northpoint Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ √F Months Days Hours Min 37 Yrs. Director 212-98-6110 Aug. 28, 1967 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f ehow event, the Madical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 704 Old North Point Road 21224 United States or Iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Heelih and Mental Hygiene. ant: if item 27 ie marked other than "naturat", or the ury or other traumatic event, the Musical Enartiem ury or other traumatic event, the Musical Enartiem. 1 ☐ Yes 2/12 No If Yes, Give Year or Dates: 1 Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Assistant Healthcare 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Catherine M. Vogel Robert M. Pawlowicz, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 704 Old North Pt. Road Baltimore, Maryland Mr. Albert J. Podles/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery | 8/17/2005 | Baltimore, Maryland 21. Si nuture of Funeral Service Dense 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Inc. 21222 V reart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Methadone and Alprazolam intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of has death? 1 Yes 2 No 2 No Hospital or Attending Physician: Director: After this cerminal in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 XYes 2 No 27. Manner of Death Production of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 2 no of 1 Natural 5 Pending investigation 8/12/05 3:00 P M death. 1 ☐ Yes 2X No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) /04 Northpoint 4 Homicide filled in To the Hospital of within 24 hours all To the Funeral D completely filled i Ave Dundalk, MD scene Medical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME August, 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year) AUG 1, 9 2005

RUS 10, MD

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32. Registrar's Signature

			For	State of Mary					Mental Hy	/giene	000	
			1 - State Registrar		C	ertificate	e of De	eath	10.5	Reg. No.	2005	27208
	Physicia	an	1. Decedent's Name (First, Middle, Last		2.100				2. Date of D Month	eath Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	iyi a	4b. City	∓own, or Loc	cation of Death	108	1 (O 4c.	County, of Dea	1 301
	LAditial	CI	BALLingre VA	nedical	Center	1	ALTIN	nore			NIA	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthda	y) If Under Months		Under 24 Hrs. Hours Min.	8. Date of B	irth ay, Year)	C	rthplace (State or Foreign ountry)
	Director		219-34-2272 1 Usual Residence of Decedent	A IN ZUI	66 Yrs.				3-16-	1939	9 Ma	ryland
	/land		10a. State 10b. County	10	c. City, Town or	Location						10d. Inside City Limits
	a-f sh	tor	MD Baltin	nore	Dun	dalk						1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number			10f. Zip				10g. Citi	zen of What C	ountry?
	s 23a		1908 Jackson		- 110		1222	0-1-1-0-10		US	SA 14. Race - Am	
10	tter de r item iner r	Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 ★ Yes 2 □ No	Marine	If Yes, spec	ent of Hispa offy Cuban, M	Mexican, Puert	pecify Yes or N o Rican, etc.)		Black, Wh	ite, etc.
980	rai', o	by	3 ☐ Widowed 4 🎦 Divorced	If Yes, Give 19 Year or Dates: 19	56-62	1 ☐ Yes 2	2⊠ No S	Specify:			Specify: W	nite
5-0	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-i show ta Madical Exeminer must be molified at	Completed	15. Decedent's Ed (Specify only highest gra		(Gir	cedent's Usua ve kind of wor	rk done durin	n ng most of wor	king	16b. Ki	nd of Business	s/Industry
121	within ane, than	mpi	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		Oper.				Ton	nmv's	Lounge
9	illed Hygie other ent, II	Be Co	17. Father's Name (First, Middle, Last)				18.	. Mother's Nan	ne (First, Middle			
/lan	should be nd Mental marked c	To B	Dick S. Payne							Farr	cell	
Maryland 21215-0036	C1 00 = 00		19a. Informant's Name/Relationship						ral Route Numi			
	1 and Health Bm 27 ther tr		Michael J. Payr		20b. Place of Dis	58 Lot		Ave.	FORK,	_	cation - City o	21051
nor	Pages nent of l int: if its		1 Burial 2 XCremation 3 \(\) '4 Donation 5 Other (Specific	Removal from State	cemetery, co	rematory or o	ther place)				timore	
Baltimore,	그 문문을 .	h	21. Signature of Funeral Service Licen			22. Name an	d Address of	f Facility ၂	oseph			o Jr. FH
Ö	Depa Impo any i		Desert Ro	Tannens	\							MD 21224
Г			23a. Part1. Enter the disease, or constitution, or heart failure. List only	olications that caused the	death. Do not e	nter the mod	e of dying, su	uch as cardiad	or respiratory	arrest,		Approximate Intervat Between
-	Physician		Impediate Cause (Final disease or condition resulting in death)	· metast	atic	Pro	stay	te a	anc	25		Onset and Death
Н	/Medical Examiner		resulting in deathy	Due to (or as a co	onsequence of):	297 H	0.0	DAGE	67.67	11		months
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):		1.0	11101	CALE	TIL	1.0	MOMINIS
	cuted nd ransit	Examiner	that initiated events	C								
90,	cate be executed chysicien end the burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):							
38760,		dicai		d								
Box 6	death certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p							23d. Date of de	alivery
	that the death cer ed by the attendir detached for use	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		B □Ectopic pro B □ Other (sp					Month	Day Year
P.O.	d by the		9 ☐ Unknown Part II. Other significant conditions of		at regulting in the	undorking a	auga suga is	a Part I	23a Did	tobacco u	ico contributo l	to the cause of death?
Records,	Se Co	d by	Falt II. Other significant conditions	ontributing to death but in	ot resulting in the	didenying G	ause giveirii	iiraiti.		,	1	robably 4 Unknown
cor	w requir been s should	Completed							24a. Wa	s an	24b. Were a	utopsy findings available
Re	0 L 0	omp							auto peri 1 Yes	opsy ormed? 2 No	prior to death?	completion of cause of s 2 No
Vital	iysician: Th	Be C	25. Was case referred to medical examiner?				26	S. Place of Dea	th (Check only		1 10	2010
of V	di is	ို	1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpat				ome 5 Res			ecify)
ou c	After After fune	lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time Injury	of 2	8c. Injury at Work?	2 □ No	28d. Describe	how injur	y occurred	
Division	Attending ir death. ector: After by the fune	fical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury				2 110				Tural Route Number,
á	s after at Dire	Certification:	4 Homicide	building, etc. (5	Specify)				City or To	own, State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai ((Check only 2 Medical Exam	ysician: To the best of m	amination and/or	ath occurred investigation.	at the time, o	date and place on, death occu	, and due to the	cause(s)	and manner a l place, and du	s stated. e to the cause(s)
	thin 2 the I	Med	one) 29b. Signature and title of certifier	and manner stated								
	F ≯ F 8		1000	An		}	WoloU	13		DS	-17-1	5
	HOL		30. Name and address of person who		n (Item 23a) (Typ	e, Print)	- 4 1		. 0			
	16.		Jennifer C. Des	51, mb -	10	NGI	REENE	e Stry	et BA	24in	rore. n	1) 21201
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 9 20	32. Begistrar's	Signature	back)						1) 2/20/

			For State	State of Maryland /	Department Certificate			and Menta		200	5 272	09	
			Registrar 1. Decedent's Name (First, Middle, Last)		Oortmoate		· Odin		e of Death			of Death	
	Physicia /Medic		TYHEARN ALEXA	INDER REED				Ogo	nth · llo·	2005	ear	5 PM	
	Examin		4a. Facility Name (If not institution, give s		4b. City,	Town, or L	ocation o			4c. County of	Death		
		5 0		MEDICAL CTR			•			ANNE	ARUNDE		
	Funeral		5. Social Security Number 6. Sex		rthday) If Under Months	Days Days	If Under 2 Hours	Min. 8. Dat	e of Birth inth, Day, Y	(ear)	Birthplace (State Country)	e or Foreign	
	Director		Usual Residence of Decedent	58				108	20. M	14(DC		
	yłand how		10a. State 10b. County	10c. City, Tov	n or Location						10d. Inside	14	
	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Examinational Le notified at	ctor	MD ANNE ARI	UNDEL GLEN	BURNIE	<u> </u>					1 🗆 Ye	es 2 No	
		Director	10e. Street and Number		10f. Zip	Code			10g	. Citizen of Wh	•		
	s 23a		6447 LAMPLIGHT		2	100		1-0 (01	N-	USA	American Indian,		
	ter de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	If Yes, spec	ent of His ify Cuban	, Mexican	gin? (Specify Ye , Puerto Rican, i	etc.)	Black,	White, etc.		
920	urs af	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2	2₿ No	Specify:			Specify:	BLACK		
21215-0036	72 ho natur lical	Completed	15. Decedent's Educ (Specify only highest grade		. Decedent's Usua (Give kind of wor	l Occupat	tion urina most	t of working	16	b. Kind of Busi	ness/Industry		
2	rithin ne. han "	mple m	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT us	e retired)		•	n	10005	110000		
CA	filed w Hygier other tl		17. Father's Name (First, Middle, Last)	N/A SE	PLICE M	_	18 Mothe	or's Name (First,		10BILE	HOMES		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, The Ma	o Be	WIALTER REED				SARA		LIARD	Q			
Į,	s 1 and 2 should t Health and Men item 27 is marke other traumatic	2	19a. Informant's Name/Relationship (Type	pe, Print) 19	o. Mailing Address				Number, C	City or Town, St	ate, Zip Code)		
	1 and 2 Health a em 27 is		SHEILA REED (V	UIFE) 6	147 LAM	PUGI	HTER	RIDGE	GLE	N BUR	NIE MD	21061	
ore,	Pages nent o ant: If a		20a. Method of Disposition	cemete	of Disposition (Namery, crematory or of	ne of		Date	20		ity or Town, State		
<u>Ë</u>			1 Burial 2 Cremation 3 R. '4 Donation 5 Other (Specify)	KING	PARK		0	8.22.09	5 R	ANDAU	SIOWN,	MD	
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service License	71				E FUNER					
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. Do							Approxim Interval E	nate Natween	
1	Pnysician :	i n	Immediate Cause (Final disease or condition	mitait	ale.	7	ne				Onset an		
	/Medical		resulting in death)	Due to (or as a consequence	of):	- Contract	ne	-					
	Examiner		Sequentially list conditions, b	- tur	Cance,								
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68	tificat ig phy as the	ledio											
X	eath certific attending p	M/us	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	n 3⊟Ectopic pre	egnancy						of delivery	
Э. В	ne deat the att hed fo	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of death 9☐Unknown	5 ☐ Other (sp					Month	n Day	Year	
P.0	that the de ed by the detached		9 ☐ Unknown Part II. Other significant conditions con		in the undertying or	auco antos	n in Part I	23	e Did toba	cco use contrib	ute to the cause of	of death?	
ds,	signed be de	d by	Taren, other signmean conditions con	inibuting to coath but not resulting	in the underlying of	ause givei			1 1 19 s		☐ Probably 4 [
Records,	v require been sig should t	Completed						24	a. Was an	24b We	ere autopsy finding	ne available	
Rec	The lav	ф							autopsy performe	d? pri	or to completion o ath?	cause of	
Vital	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical				26 Place	of Death (Chec		3140 1L	Yes 2□No		
>	ys di:	O B	eyaminer?	lospital: 1 Inpatient 2 ER/O	utpatient 3□ DO	Other	-	rsing Home 5		ce 6 🗆 Other	(Specify)		
υot	ding Ph h. After th funeral	T : UC	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b.	Time of 2	8c. Injury : Work?	at			injury occurred			
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Division	or Att fter d irect in by t	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory	, office			cation (Stre y or Town,		or Rural Route N	umber,	
	pital o		COn Continue 17 Contituing Dhur	inian Tababababababababa				4-1					
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examir	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	nd/or investigation,	in my opi	e, date an inion, dea	th occurred at th	e time, date	se(s) and manr and place, an	d due to the cause	ə(s)	
	To t To t	Σ	29b. Signature and title of certifier	//	290	. License	number		290	I. Date signed	Month, Day, Year)	
	1		I Culi A	Tan in	12)	1)	5 3	306		8/1	1107		
	h		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)	-4-	ρ.	1 010	2 40	14	, 2	144	
		to	31. Date filed (Month, Day, Year)	2. Registrar's Signature	585	are	10	STP	200	ernna	pulls	ne)	
	Sta Registr		AUG 1 9 2005	mpleted cause of death (Item 23a) 2. Registrar's Signature	grade								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

5552 11			Please	Type or P								•		•	¥		
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Diameter.		1. Decedent's Name	e (First, Middle, La:	st)							2	. Date of De			:	3. Time of (Death
Physicia /Medic			Stephe	n Paul	Ross						I	August		2005		4:50	Р
Examin		4a. Facility Name (/	If not institution, give	street and numb	oer)			4b. City,	Town, or	Location of De	eath	0	40	. County of De	ath	-	
		22 Ridge	lawn Road							stown				Baltimo			
Funeral		5. Social Security N	lumber 6. S	ex ☑M 2☐F	Age (In yrs.	58		If Under Months	Days	If Under 24 H Hours M	irs. 8.	. Date of Bir (Month, Da	rth ay, Year	9. 6	Sinthplac Country	e (State or	Foreign
Director		547-72- Usual Residence of	6388	Λ		70	113.				J	UN 5,	194	+/ DISt	rict	of Co	Tumor
/land		10a. State 10b. County 10c. City, Town or L.						ation							10d.	. Inside City	y Limits
Man	ţ	Maryland	Baltin	nore					Rei	stersto	town					1 🗌 Yes	2 📉 No
or 28	Director		10e. Street and Number						Code		10g. Citizen of What Country?						
death with the Maryland	aic	22 Rids	22 Ridgelawn Road						211:	36				USA			
r dea	Funerai	11. Marital Status	Armed Forces?				13. W	as Deced Yes, spec	ent of Hi	ispanic Origin? In, Mexican, Pu	(Specif	y Yes or No)-	14. Race - Ar Black, W			
or I	by Fi	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Year or Dates:					1 ☐ Yes 2 ☑ No Specify:							Specify:	Wh	nite	
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i the	Completed	Elementary/Seco	ondary (0-12)	College (1-4 5-	-		Ci	vil S	Serv	ant				dminist			
other and	0	17. Father's Name								18. Mother's N	Name (F	First, Middle	, Maide	n Sumame)	-,-		
Venta Menta Itic e	To B	Morris Allen Ross								Sy	y1vi	la Ste	rli	ng			
2 sho		19a. Informant's Na	ame/Relationship (Type, Print)		19b.	. Mailing	Address	(Street a	and Number or	Rural F	Route Numb	er, City	or Town, State	, Zip Co	ode)	
end ealth n 27			Ross/Brotl	her	1							nens,				Total Control	
T tte		20a. Method of Disp 1 Burial 2	☑Cremation 3 ☐	Removal from St				ition (Nan atory or o			Date			ocation - City			
tant:		4 Donation	5 ☐ Other (Specify	1)	Me	tro			•	Inc. 8/				altimor			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. But importment of Health and Mental Hygiene. Importment: If term 27 is marked other then "naturel; or Items 23a or 28a-f ehow any Injury or other traumatic event, the Medical Examinar must be notified at one.		21. Signature of Fu	uneral Service Licer	ul	•		C C	rema	d Addres tion	ss of Facility Societ rick Ro	уо	f MD,	Inc				
		Edwa	rd A// Gre he disease, or com	gorchik	sed the deal	h Dor								e, MD		28 pproximate	
		shock, or hea	irt failure. List only	one cause on ear	th line.	_				-				D	l In	terval Betw nset and D	reen
Physician /Medical		Immediate Cause disease or condition resulting in death)	n e e e e e e e e e e e e e e e e e e e	a ttype	views	WL		LICSO	Levi	otic Ca	Little	ovasa	wa	110180	SE		
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e as t	Med	IF FEMALE:		"	- and										1		
ath ca	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy									23d. Date of delivery Month Day Year						
the e	ysic	1 ☐ Yes 2 [9 ☐ Unknown	□No	4∐Pregnar 9☐ Unknow	nt at time of o	leath	5	Other (sp	ecity)					World Suy You			
w requires that the death been signed by the ette should be detached for	by Physician/Medica	Part II. Other signif	ficant conditions c	ontributing to dea	th but not res	ulting in	the unc	derlying ca	ause give	en in Part I.		23e. Did t	obacco	co use contribute to the cause of death?			
uires sign												10	Yes 2	.□No 3□	Probabl	y 4 Xiur	nknown
w req	ompieted										_	24a. Was	an	24b. Were	autopsv	findings a	vailable
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icien: Th certificete rector, pag	O	25. Was case refer	red to medical							26. Place of D	Death (C	heck only		1 AY	es 2L	□ No	
Physicien: this certific ral director,	0 B	examiner? 1 X Yes 2 □	No	Hospital: 1 Ing	patient 2	ER/Out	tpatient	3 DO	A Othe				- 65.1	6 StOther (S)	pecify) S	cene	
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To the Hospital or Attending Physicien: within 24 hours after death. To the Funarel Director: After this certifice completely filled in by the funeral director; p	ledicai	29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 Medical Exam	ysician: 10 the bas niner: On the bas and manne	is of examina	tion and	death dor inve	occurred a estigation,	in my op	ne, date and pla pinion, death oc	ace, and ccurred	at the time,	date an	i) and manner d place, and d	as state ue to the	ed. e cause(s)	
Vithir vithir To 11	ž	29b. Signature and	title of certifier	/				29c	. License	number			29d. Da	ate signed (Mo	nth, Day	y, Year)	
/		•	Wir	Hal	lan	W	X	C	CME				Augu	ıst 17,	200)5	
6		30. Name and addr	ress of person who	completed cause	of death (Iter	n 23a) (Туре, Р		Penr	n Street	t, E	Baltim	ore,	, Maryl	and	21201	L
Sta Registr		31. Date filed (Mon		32. Rec	j s frar's Signa	ature	1	Carl	9								
					Carlo Carlo		-17										

DHMH 17 Rev 1/2001

		1 - For State Registrar	State	of Mary	•	artment of F			giene leg. N2. 0 (15	27211			
		Decedent's Name (First, Mi	ddle, Last)					2. Date of Dea	th	, <u>U</u>	3. Time of Death			
Physic /Med		Phyllis Cogs	well Reed					Month 08	10 20	05 ^{Year}	08:25p M			
Exami		4a. Facility Name (If not institu					Location of Deat	h	4c. County of Death					
		Potomac Vall 5. Social Security Number	ey Nursin		yrs. last birthday)	Rockv		8. Dete of Birth		tgome	ery blace (State or Foreign			
Funeral Director		578-18-9442	1 □ M 2 🖫		Yrs.	Months Days	Hours Min.		Year) -1917	Coun	ington DC			
		Usual Residence of Decedent				l	1							
arylar ehow	7	10a. State 10b. County 10c. City, Town or Location								11	0d. Inside City Limits 1 ★Yes 2 □ No			
the M	ecto	MD Mo	ntgomery		Silver S	10f. Zip Code			10g. Citizen of What Country?					
3a or	Funeral Director	208 Northwes	t Terrace			Ton Lip Godo	20901	USA		, .				
death	nera	11. Marital Status	12. Was [ecedent Ever	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-		e - Ameno				
or Its	y Fu	1 Never Married 2KK	farried 1 ☐ Y	d Forces? es 2⊠No . Give	i	1 ☐ Yes 2 █ No	Specify:	to Hican, etc.)	Specify	ck, White, o	ite			
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al Hyg	BeC	17. Father's Name (First, Midd		11			18. Mother's Nar Alice	me (First, Middle,	Maiden Surnan	ne)				
y ca ould to Ment Marke harke	2	Frank Benjam							Ohren Terre Clark Te Ordin					
d 2 st th and 7 Is m traum		19a. Informant's Name/Relationship (<i>Type, Print</i>) Oscar W.B. Reed, Jr. 19b. Mailing Address (<i>Street and Number or Rural Route Number</i> , 6 208 Northwest Terrace Silver												
Heall Heall tem 2		20a. Method of Disposition	ccu, 01.	2	Ob. Place of Dispo	sition (Name of		Date	20c. Location -					
Pages ient of nt: If I		1 ☐ Burial 2 🛣 Cremation 3 ☐ Other		om State		natory or other place ike Crema	· 1	-18-2005	Belts	ville	MD			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, Ita Modical Exprinted risation recitled at any pings.		21. Signature of Funeral Serv	ice Licensee		-	Rapp Fun	ss of Facility era1 & Ci	remation	Service	e				
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e deal he att	sicis	1 ☐ Yes 2 ☐ No 9 ☐ Unknown								Month Day Year				
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lor Attending Falter death. Director: After In by the funer	icat	3 ☐ Suicide 6 ☐ Cou	estigation ald not be	ace of Injury -	At home, farm, str		Yes 2 □ No	28f. Location (Si	reet and Numb	er or Rura	I Route Number			
alor A s after il Dire	Certification:	4 Homicide det	ermined 286. P	uilding, etc. (S	pecify)	cot, lastory, onlos		City or Town		0, 0, 110,0	, robto rearrour,			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely tilled in by the funeral director.	edical (29a. Certifier (Check only one) Certifier 2 Medic	lying Physician: To	the best of m	y knowledge, deat amination and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the carred at the time, d	ause(s) and ma ate and place, a	inner as sta and due to	ated. the cause(s)			
o the o the omple	Med	29b. Signature and title of cen		lariner stated.		29c. Licens	e number	2	9d. Date signed	d (Month, L	Day, Year)			
F>F0) _ \ \	1/2 1		λ	Ho								
15		30. Name and address of pers	on who completed o	ause of death	(Item 23a) (Type,	Drint)					-			
17		Anushira V	an Dac	gar	- Dehle	ordi,	Hotoma	c vallei	1 Nurs	31119				
St Regist	tate trar	31. Date filed (Month, Day, Ye	9 2005	z. Negistrar's	Signature	autis		9		1				
- Incgis		HUU.	T 2 CA07	A SECRETARY	J.S. J.S.	400								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend item #20b&C per fh g849 rtificate of Greath Reg. 10.0 05 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 50 AM **Physician** August Shirley Rogers 13 2005 /Medical 4c. County of,Dath 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7α 5. Social Security Number land JENPEO 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y June 12, If Under 1 Year If Under 24 Hrs. 9 Birthplace (State or Foreign 6. Sex **Funeral** Days North Carolina Hours 1 M 2 F 70 Yrs. 579-80-3316 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ir then "natural", or Items 23a or 28e-f shov the Medical Examinat must be notified at Yes 2□No Maryland Directo more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 102 212 2. 0 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 XÛNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Maryland 21215-0036 Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd 2 should be filed within 7 alth and Mental Hygiene.
27 Is marked other then "n rraumatic event, the Wed Elementary/Secondary (0-12) College (1-4or 5+) bore $l \sim$ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk. nomas 19a. Informant's Name/Relationship (Type, Print) (doug hter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Ms. Monique permit. Pages 1 and 2 Department of Health a Important: If item 27 Is to. other t Baltimore, 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Injury or 9/06/05 MT. CARMEL CEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Joseph L. Russ Funeral Home, P.A.
ZZZZ W. North Ave. Barto, Md. 21216 21. Signature of Funeral Service Licensee. any In 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 10 /Medical Due to (or as a consequence of): Examiner (Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) P.O. 1 detached 9 Unknown á Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MOULY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1111 . Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 9 2005

Registrar

			For State Registrar	State of Maryla		artment of H		lental Hygie	ne .2.005	27213			
	Physicia		Decedent's Name (First, Middle, Last) RHODA	В.		RUDDIE		2. Date of Death Month AUGUST	14, 2005	3. Time of Death 1:30 P M			
	/Medic Examin		4a. Facility Name (If not institution, give str	reet and number)			Location of Death		4c. County of Death				
	Funeral		25 STONEHENGE CIR 5. Social Security Number 6. Sex	7. Age (In yi	rs. last birthday)	If Under 1 Year	BALTIMO If Under 24 Hrs.	8. Date of Birth	BALTIMORE of Birth 9. Birthplace (State or F				
	Director		2/2-46-4932 1 Usual Residence of Decedent	M 2∑ F 7	9 Yrs.	Months Days	Hours Min.	AUG. 15,	°1925 Cou	CANADA			
	ryland how		10a. State 10b. County	10c.	City, Town or Lo					10d. Inside City Limits			
	the Ma 28a-f s	Director	MD BALTI 10e. Street and Number	MORE	BALT	I MORE		100	. Citizen of What Cou	1 ☐ Yes 2 No			
	th with	ai Dir	25 STONEHENGE CIR	CLE #3		701. 2.p 000e	21208	109	. Citizen di Vinat Cou	USA			
121	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Iteal Exercitives to institute at	by Funerai	11. Marital Status 12 1 □ Never Married 2 💢 Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🕱 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE				
	within ene. than "	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Dece (Give life. NURSE	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work)	king	bb. Kind of Business/Ir	ndustry			
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ıyla	2 should be and Mental Is marked eumatic ev	၉	JACOB 19a. Informant's Name/Relationship (Type	e, Print)	BLAN 19b. Maili		SARAH and Number or Rur		EIBA Dity or Town, State, Zi,	SIEGLE			
, Ma	ges 1 and 2 should t of Health and Men If item 27 Is marke or other treumailc		SAMUEL L. RUDDIE	/ HUSBAND	25 S	TONEHENGE	CIRCLE	#3 - BALT	IMORE, MD	21208			
nore	Pages 1 nent of H int: If iter iry or oth	h K	20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ Re. 4 □ Donation 5 □ Other (Specify)	moval from State	cemetery, crei	osition (Name of matory or other place ANS CEMET	θ)		OWINGS MI				
Baltimore,	permit. Page Department Importent: II any injury o		21. Signature Funeral Service Licenses		22	2. Name and Addres	s of Facility SO	L LEVINSO	N & BROS., KESVILLE,	INC.			
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the decause on each line.						Approximate Interval Between			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a.	Due to (or as a cons	S. Caller of Contraction	static	Carcino	mu		Onset and Death			
	Examiner		Sequentially list conditions.										
	red nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury										
8760,	ate be executed hysician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a cons	equence of):		,,,						
O. Box 68	death certific e attending p d for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		23d. Date of delive Month								
S, P.	res that I	۵	Part II. Other significant conditions conti	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown									
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Vita	sicien: certific rector,	o Be C	25. Was case referred to medical examiner?	spital:		Othe		th (Check only one)					
	ding Phys h. After this funeral di	\vdash	1 ☐ Yes 2 ☐ Mo 27. Manner of Death 1 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o		at	ome 5 Aesidence 28d. Describe how		fy)			
Division	or Attendater deatl	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	Yes 2 □No		18f. Location (Street and Number or Rural Route Number, City or Town, State)						
1	Hospita 4 hours Funeral	edical Ce	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examine	cian: To the best of my ker. On the basis of examand manner stated.	knowledge, deat ination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the causered at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)			
	To the within 2 To the complet	Me	29b. Signature and the of certifier	0.		29c. License		29d	. Date signed (Month,				
,	17		30. Name and address of person who com	poleted cause of death //	tem 23a) (Tune		941		8/15/0	7)			
1	†		SBEVESH	21(ras	nouds	Ar Ou	in m/1	1/5 mel	21117				
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 9 2005	32. Registrar's Sig		sile			ŕ				
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d1		State of Maryland / Department of Health and M	Mental Hygien	е			
		1 - State Registrar Certificate of Death	Reg. N	.2005 27211			
Physici	20	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Da	ay Year			
/Medic		CURTIS DON STREAT	August 14	, 2005 8:10 P M			
Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4	c. County of Death			
4		University of Maryland Shock Trauma Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last hinthday) 1 Under 1 Year 11 Under 24 Hrs.	10.5	NA			
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)			
		Usual Residence of Decedent	05.18.1978	5 110			
yłand		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits			
Mar	to	MD BALTIMORE WINDSOR MILL		1 ☐ Yes 2 0 No			
n the	Director	10e. Street and Number 10f. Zip Code	10g. C	citizen of What Country?			
th will		2536 MOLTON WAY 21244		USA			
dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.			
or it	by FL	1 ☑ Never Married 2 ☐ Marned 1 ☐ Yes 2 ② No If Yes, Give 1 ☐ Yes 2 ② No Specify:					
ura!		3 Liwidowed 4 Librorced Year or Dates:		BLACK			
n 72	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	ting 16b.	Kind of Business/Industry			
with:	Ę,	IZ-TH GRADE College (1-4or 5+) FORK LIFT OPERATUR	1414	AREHOUSE			
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "netural", or ferma 23e or 28e-f ahow avant, the Medical Examinar must be notified at			e (First, Middle, Maide				
2 should be filed within and Mental Hygiene. Is marked other than aumatic avant, the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Men	To Be	ROY H. STREAT BEVERLY	Y J. NEA	L			
s 1 and 2 should if Health and Men itam 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur	al Route Number, City	or Town, State, Zip Code)			
and 2 ealth a m 27 is		BEVERLY J. STREAT (MOTHER) 603 N. GRANTLEY S'	T. BALTO.	MD 21229			
t france of the contract of th	-	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State	Date 20c. I	Location - City or Town, State			
Pages ment of I		4 Donation 5 Other (Specify)	1.05 BA	MIMORE, NA			
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Liceosee 22. Name and Address of Facility VAUGHU C. GRENE F	FUNERAL SE	ERVICE			
205 29		5151 BALTO NATT PIKE	BALTO. MI	D. 21229			
		23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or hand failure. List only one cause on each line.	or respiratory arrest,	Approximate Interval Between			
Physician		Immediate Cause (Final disease or condition a. Gunshot wound to back		Onset and Death			
/Medical Examiner		resulting in death) Due to (or as a consequence of):					
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lsit led	- Pe	If any leading to immediate Due to [or as a consequence of]: cause. Enter Underlying Cause (Disease or injury					
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The law requires that the death certificate be executed ate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	4					
illicate as the	edic	u.		- (1-4-11-11)			
leath certific attending p	M	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery				
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aw requires the s been signed I	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?				
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law I	ag.		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
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Per Per Per Per Per Per Per Per Per Per	Certification;	building, etc. (Specify)	City or Town, Sta	ite)			
To the Hospital or Attending Physician: The law within 24 hours effect death. To the Funeral Director: Affer this certificate hes completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause((s) and manner as stated.			
24 P	edical	(Check only one) 2.13 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, date a	nd place, and due to the cause(s)			
To the within To the Comp	Me	29b. Signature and title of certifier 29c. License number	29d. D	Date signed (Month, Day, Year)			
1		Jash Deef MD OCME	Au	gust 15, 2005			
N		30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)					
	1		, Baltimore	e, Maryland 21201			
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
Regist	relî	AUG 1 9 2005 Season 15					

Prince A. Scurlark 05-05506 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

J55	06		1 - For State Registrar	State of Marylan	-	artment of H		ind Mental H			07015		
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dea										
	Physici		Prince Anthony Scu	st 14	, 2005 Year	2158 P M							
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location o		· · · · · ·	c. County of Death	2230 2		
40			602 South Gate Roa	ad		Aberdeen]	Harford			
I	Funeral Director		464-29-8693	DM 2□F	last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Day, Yea	r) Cou			
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits		
	Maryi feho	Į.	Maryland Harford								1 X Yes 2 □ No		
	r 28a	Directo	Maryland Harford Havre De Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?										
	23a o		134 Vancherie Cou	rt		21078			Un	ited Stat	es		
	ams arms	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Orig	gin? (Specify Yes or Puerto Rican, etc.)		14. Race - Ameri Black, White,	can Indian,		
Maryland 21215-0036 to 2 should be filed within 72 hours after death with the Maryland th and Mentel Hygiene. 27 is marked other then "natural", or itams 23a or 28a-f show treumatic event, the Medical Examinar must be notified at	be lied within 72 nouts after death with the marylar tel Hygiene. Id Other then "natural", or Itams 23a or 28a-f show event, the Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒Divorced	1 XYes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:	, , , , , , , , , , , , , , , , , , , ,		Specify: Black			
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א ס	Hygi ther nt, I		17. Father's Name (First, Middle, Last)	2	Plumb	er	18. Mothe	r's Name (First, Mid			mbing Co.		
au		To Be	Troy Lee Scurlark,	Cr.				Jones	uio, maide	in Sumame,			
<u> </u>	s 1 and 2 should be f Health and Mentel item 27 is marked o other treumatic eve	F	19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street a			mber, City	or Town, State, Zij	Code)		
Š	l and 2 lealth a im 27 le her trei		Marva J. Scurlark/	Mother	1	arnet Dri							
e,	of He of He rothe		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other place	9)	Date	20c. l	Location - City or To	own, State		
Ĕ.	rages ment of ant: If it ury or o		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Da Na	llas-F tional	natory or other place ort Worth Cemetery	Åu	g 22, 200	5 Da	llas, TX			
Baltimore,	permit. Pages Depertment of I Important: If its eny injury or o		21. Signature of Funeral Service Licens		1 22	. Name and Addres	s of Facility	/					
	40 F • 0		nancy for	Josselle	8	incoln Fu 100 Fires	tone	Dr., Dall	as,	TX 75217			
	hysician /Medical		23a. Part1. Enter the disease or comp shock, or heart allure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Neck www.	/	or the mode or dying	, such as (cardiac or respirator	y anest,		Approximate Interval Between Onset and Death		
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	w requires that s been signed by should be deta	by Ph	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause give	n in Part I.	23e. D	id tobacco	use contribute to t	he cause of death?		
Vital Records,	quire an sig ruld b					·		1	☐ Yes :	2 No 3 Prol	pabiy 4 □Unknown		
ဝ ဝ	aw re as be	Completed						24a. V		24b. Were auto	psy findings available		
		E O						_ P	utopsy erformed? s 2□N	death?	mpletion of cause of 2 □ No		
<u> </u>	sician: The law certificate hes l irector, pega 2 s	Be (25. Was case referred to medical examiner?				26. Place	of Death Check on					
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ב	After After funer	lon	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	es 2014	unrest	erneed	driver -	collisian		
Division	death death ctor: y the	fica	Accident investigation 3 Suicide 6 Could not be	August 14,2 005 28e. Place of Injury - At h	ome, farm, str		03 24	with t	Location (Street and Number or Rural Route Number,				
=	5 E E	Certification:	4 Homicide determined	building, etc. (Specif	y) Weet	oo, radio, y, o.may		City or	Town, Sta	State) Rel (Aperteen, MD			
	pita ours eral		29a. Certifier I Certifying Phy	sician: To the best of my kno	wiedge, death	n occurred at the tim	e, date and	d place, and due to	he cause/	s) and manner as s	tated		
:	in 24 hc the Fun ppletely	ledicai	Une)	iner: On the basis of examina and manner stated.	uion and/or in	vestigation, in my op	inion, deat	n occurred at the tin	ne, date ar	nd place, and due to	the cause(s)		
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			Journel =	per mi)	0.C.	M.E.		Aug	August 15, 2005			
	り	1	as Name and address of person who co	ompleted caula of death (Iter	n 23a) (Type, 111 F	Print) Penn Stree	et, Ba	altimore.	Mary	land 2120	1		
	Sta	ite	31. Date filed (Month, Day, Kdar)	2 Pegistrer's Signa		Boards							
	Poglet	212	LIAM T	V V KREEKS	Topic Car								

		For State Registrar		ıvıarylan		tificate of		Mental Hy	Reg. No.	000	27216		
sicia		Decedent's Name (First, Middle,				D			ath Day		3. Time of Death		
edica mine		4a. Facility Name (If not institution,	LEITHA give street and numb	B .	-	STERLII 4b. City, Town, o		August	4c. County of Death				
		3084 Calvary Roa	ıd			Cri	sfield			Sor	merset		
ral			. Sex 7. 1 ☐ M 2 XX F	Age (In yrs.		If Under 1 Year Months Days	If Under 24 H Hours Mi	in. (Month, Da	y, Year)	9. Birth	place (State or Foreign intry)		
r	}	220-12-1339 Usual Residence of Decedent	10	10	l Yrs.			May 14	, 190	04 Virg	inia	-	
		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	-	
	tor	Maryland Some	erset			Cr	risfield				1 ☐ Yes 2√TNo		
	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cou	intry?		
		3084 Calvary Roa					21817			USA			
	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede	es?		Was Decedent of H f Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	0-	 Race - Ameri Black, White 			
	þ	3 XWidowed 4 Divorced	d 1 ☐ Yes 2 If Yes, Give Year or Date			1☐ Yes 2☒ No	Specify:			Specify: Wh	ite		
	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of working life. DO NOT use retired) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								nd of Business/I	ndustry		
	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.			vorking					
										lothing Manufacturers			
	Be	John William Bor	*							den Sumame)			
	၉ .	John William Bonniwell Ella S. Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, C								City or Town State Zin Code)			
		Teeny S. Landon (Daughter) 3084 Calvary Road - Crisfield, Maryland 21817											
		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Total Community Crematory or other place)											
		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		ate		Memorial Pa	ı	et 18. 200	Cr	icfiold	Narylan3		
i		21. Signature of Funeral Service Li	censee Adams	Di				Funeral H	Omo	rerra	raryranc.		
		Mary Beth Rr	adshaw-Pr	witt						d. Marvl	and 21817		
ı		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cau	sed the deat	h. Do not ent	er the mode of dyin	ng, such as card	iac or respiratory a	rrest,		Approximate Interval Between		
ŀ		Immediate Cause (Final disease or condition	a.	1	1SCV	D				- 1	Onset and Death		
		resulting in death)	Due to (or	as a conseq	uence of);								
	0	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseq	neuce of).							_	
	min	Cause (Disease or injury			201100 01,1								
	Examiner	that initiated events resulting in death) Last	Due to (or	as a conseq	uence of):								
	dicai		d										
	Med	IE EEMAI E											
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								23d. Date of delivery			
	sic	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Other (specify)								Month Day Year			
		Part II. Other significant condition	s contributing to dea	th but not res	ultina in the u	nderlying cause giv	en in Part I	23e. Did 1	obacco u	cco use contribute to the cause of death?			
	d by					, , , , , , ,		1 🗆	Yes 2)	No 3 □ Pro	bably 4 DUnknown		
	ompieted	24a. Was an									opsy findings available	_	
	mc							- auto		prior to co	ompletion of cause of		
ŀ	O .	25. Was case referred to medical					26 Place of D	1 ☐ Yes leath (Check only		1 🗆 Yes	2 No	_	
ı	0 0	examiner? 1 □ Yes 2 No	Hospital:	patient 2	ER/Outpatien	t 3□ DOA Oth				5 □Other (Speci	ifu)		
	L:U	27. Manner of Death	28a. Date of		28b. Time of			28d. Lescribe		- ' '			
	atio	1 Natural 5 ☐ Pending investiga	tion	Day rour,	injury		Yes 2 □ No						
l	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	208. Flates U	f Injury - At he , etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (City or To	Street an	d Number or Rur)	al Route Number,		
ŀ	edical	(Check only 2 Medical E)	Physician: To the b kaminer: On the bas	is of examina	wledge, death	occurred at the tir	me, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as splace, and due to	stated. to the cause(s)		
461	Med	one) 29b. Signature and title of certifier	and manne	r stated.		29c. Licens				e signed (Month,		_	
			10 =	1 0	,				Dal		* *		
		D 48098 August 16, 2005									TO1 ZUUD		
	1	30 Name and address of person in	ho completed sauce	of death (lea-	239\ /T	Print)						-	
,		30. Name and address of person w		•		,		afial-1	Ma *	- A		_	

			1 - For State Registrar	State of N		d / Depa		lealth and M	lental Hy	•		
	Physicia /Medic		Decedent's Name (First, Middle, L. THOMAS L. SEYMO	UR					2. Date of Dea Month	ith Day	Year 7:16 P M	А
	Examin		4a. Facility Name (If not institution, gi		* .	i	4b. City, Town, o	r Location of Death		4c. County	of Death	
	Funeral Director		5. Social Security Number 6. 214–36–8695	Sex 7 XXM 2□F	Age (In yrs. I 66	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept.	5,1938	Birthplace (State or Foreign Maryland	ın
	aryland show	ŗ	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No	
	vith the M or 28a-f	Funeral Director	Maryland Baltimo 10e. Street and Number 7719 Babikow Rd.	ore		ватт	Imore Cou	21237		10g. Citizen of W		_
S	er death v	uneral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S	S. 13. V	Vas Decedent of H Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, k, White, etc.	
5-0036	within 72 hours affer death with the Maryland ene. Then "natural", or flems 23e or 28e-f show the Madical Examitrat must be molified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E	1 ☐ Yes 2X If Yes, Give Year or Date			Yes 🖈 No				White	
h on 1	within 72 ane. then "nai	Completed	(Specify only highest girls Elementary/Secondary (0-12)	College (1-40	or 5+)	(Give I life. [ent's Osual Occup kind of work done NOT use retire Represe	during most of work d)	ing	16b. Kind of Bu	il Industry	
	permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Deparatment of Health and Mental Hygiens and Mental Hygiens after a special from 23a or 28a-1 show mortant: I fem 27 is marked other then "naturel", or flems 23a or 28a-1 show any injury or other traumatic event, the M-dical Examination intelligible at 2006.	To Be Co	17. Father's Name (First, Middle, Las William W. Seymot	t)		Dates	s uchiese	18. Mother's Nam	e (First, Middle,	Maiden Sumam		
Seymour, 1	nd 2 shoul Ith and Me 27 Is mark r traumati	ř.	19a. Informant's Name/Relationship Bernadine Seymour	(Type, Print)				and Number or Aur. N Rd. Balt	a <i>l Route Numb</i> e	r, City or Town,		1
Deymour	Pages 1 ar nent of Hea int: If item iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control Co	☐Removal from Sta	te Ce	ace of Dispos emetery, crem	ition (Name of latory or other place Liley Memor:	ce)	Date		City or Town, State	
Der Baltii	permit. F Departme Importar any injur		21. Signature of Funeral Service Lice	eesne	5 001		Name and Addre		_			
			23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	nolications that caus	sed the death	. Do not ente					Approximate Interval Between Onset and Death	-
	Physician /Medical Examiner		disease or condition resulting in death)	aDue to (or a	as a consequ	ience of):						- 0
Vo.	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or fright that initiated events	b. Due to (or a	as a consequ		lemio	2				
760,	ate be executed hysician and the burial-transit	cal Exa	resulting in death) Last	Due to or	as a consequ	erce of):						
P.O. Box 68	ne death certific the attending pl hed for use as t	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 Fetal at time of de	death 3	Ectopic pregnancy Other (specify)	1		23d. Date Mon	e of delivery th Day Year	
ds, P.	signed by d be detac		Part II. Other significant conditions	contributing to death	but not resu	Iting in the un	derlying cause giv	en in Part I.	23e. Did to		bute to the cause of death? 3 Probably 4 Unknown	
ecor	e law requir has been si je 2 should	Completed							24a. Was a autop:	an 24b. W	/ere autopsy findings available	.— ə
Vital F	ysician: The last constitute to the control of the	Be	25. Was case referred to medical examiner?	Hamital				26. Place of Death	1 Tes	2 No 1	eath? □Yes 2□No	_
Division of Vital Records,	Ntending Physideath. Ctor: After this c the funeral dir	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation			R/Outpatient 28b. Time of Injury	28c. Injur Wor	y at		ence 6 Othe		-
Divis	itel or Attendins after death rail Director: led in by the	Certification:	3 Suicide 6 Could not l 4 Homicide determined	building,	etc. (Specify,)	et, factory, office		City or Tow	n, State)	r or Rural Route Number,	
3	To the Hospitel or within 24 hours afte To the Funeral Discompletely filled in	ledical	(Check only 2 Medical Exa	hysician: To the be miner: On the basis and manner	of examinati	vledge, death ion and/or inv	estigation, in my o	pinion, death occurr	ed at the time, d	ate and place, a	nd due to the cause(s)	
	To To	Z	29b. Signature and title of certifier	m_l	Alm	73	29c. Licens				(Month, Day, Year) 7 - 2005	
	10		30. Name and address of person who	ia. 900	death (Item	23a) (Type, F	rint) Sq. uq	re Drive	e, Balt	imore	7-2005 M) 21237	
: **	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 9	2005 32. Fegis	strar's Signat	A ASS						

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 005 27218
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ella May Stumpe 2. Date of Death Month Day Year August 16, 2005 1. Date of Death August 16, 2005
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Funeral Director		
	Maryland I-f show	tor	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$
	3e or 28s	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 U.S.A.
980	iges 1 and 2 should be lited within 72 hours after death with the Maryland it of Health and Mental Hygiene. And Health and Mental Hygiene. Or other traumatic event, the Madical Examinational Legisland.	by Funer	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo Specify: White
S	filed within 72 ha Hygiene. other than "natu ant, the Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Author 16b. Kind of Business/Industry Literature
	should be fill and Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Micajah Warren Leonard 18. Mother's Name (First, Middle, Maiden Sumame) Mary Ann Bigham
	1 and 2 sho Health and em 27 is m ther trauma		19a. Informant's Name/Relationship (Type, Print) Mr. Kevin Quirk/Administator 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Record Street, Frederick, Maryland 21701
υ,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Olivet Cemetery Aug 18, 2005 Frederick, Maryland
Baltin	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford P.A. Funeral Hone
F	hysician '		23a. Part1. Enter the Issease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart ailure. List only one cause on each line. Immediate Cause (Final
	/Medical Examiner		disease or condition resulting in death) Pneumonia Due to (or as a consequence of): 48 Hours
8760,	ate be executed hysician and he burial-transit	ical Examiner	Sequentially list conditions, The Leading Loring and Leading Loring and Leading Loring and Leading Loring and Leading Loring and Leading Loring and Leading Loring and Leading Loring and Leading Loring and Leading Loring and Leading Loring and Leading Loring and Leading Loring and Leading Loring and Leading Loring and
.O. Box 68	ath certifical ttending plor use as t	Physician/Medi	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year
rds, P	fures that the de n signed by the a uld be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		Completed	Chronic Obstructive Pulmonary Disease 24a. Was an autopsy performed? prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
	this ald	ation; To Be	25. Was case referred to medical examiner? Hospital: I Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted
Division	al or Atte s after de: al Directo ad in by th	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
:	To the hospital or Attending Pn within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	within To tt	Ň	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/16/08
	7	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	Sta Regist		Francis E. Becker, MD., 300 West Ninth Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) AUG 1 9 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Mildred F. Shibel 1:50 PM August 13, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7234 Taveshire Way Bethesda

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Diano) | Country, Feb. 22, 1909 | Massachusetts 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🖾 F 579-44-3694 96 Yrs Director Usual Residence of Decedent death with the Maryland 10b County 10a State 10c. City, Town or Location 10d. Inside City Limits "neturel", or items 23a or 28a-f ehow dical Examinar musi be notified at Director Montgomery 1 TYes 21 No Bethesda Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7234 Taveshire Way 20817 United States Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☑ Widowed 4 □ Divorced Completed reumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done di life. DO NOT use retired) during most of working Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Librarian Pages 1 and 2 should be filed a nent of Health and Mental Hygic out: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elias Farrah Agia Haddad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole A. McGarvey/Daughter 7234 Taveshire Way, Bethesda, Maryland 20817 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Gate of Heaven 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State August 19, 2005 = 5 permit. Page Department of Importent: if eny injury or once. Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician Atherosclerotic Coronary Artery Disease disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetel death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No for Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. signed by the a Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Alzheimers Dementia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2⊠ No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending after death. 2 Accident investigation 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 29a, Certifier 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 2 D0030484 August 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles Umosella, MD 7625 Wisconsin Are #101 Bethrida mp 20814 31. Date filed (Month, Day, Year) 32. Registral's Signature State AUG 1 2005 Registrar

Physician Modifical Examiner A. Facility Name (if not national, pive street and number) A. County of Death Modifical Number (Name) (identity Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. County Of Name (Index Name) A. C				1 - For State Registrar	State of Maryland / Dep	artment of Health and Nertificate of Death		ene
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Special part Spec				4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death
Symbol S				4608 Chase Ave	nue	1		
Description of Control Control				4.5	TM 2MF		8. Date of Birth (Month, Day, 1	
100. State 100. Compared by Department 100. Compared by Depa		Director		379-42-2200	78 Tis.		July 28,	, 1927 Washington, D
The part of the pa		/land			10c. City, Town or L	ocation		10d. Inside City Limits
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The part of the pa		13 wi	a	4608 Chase Avenue		20814	Uı	nited States
The part of the pa		or deg	nue		12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	
The part of the pa	36	s afte	Y F		If Yes, Give	1 ☐ Yes 2 ☒ No Specify:		
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The part of the pa	15	n "ne	plet	(Specify only highest grad	de completed) (Give	e kind of work done during most of work	ing	ob. Time of Boomesa mades.ry
Comparison Com	212	d with	EO			r Worked		None
Comparison Com	힏	e file al Hy l othe vent,	3e C	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Ma	aiden Sumame)
Comparison Com	<u>a</u>	Ments Ments arked	70	John D. Sturge				
Comparison Com	a	2 sho and Is mu		19a. Informant's Name/Relationship (T	ype, Print) 19b. Mail	ing Address (Street and Number or Run	al Route Number,	City or Town, State, Zip Code) 20015
Comparison Com	2	and lealth m 27 her tr			eon/Sister 5432	Connecticut Avenu		
Comparison Com	ō	ges 1 t of H if its			Removal from State	matory or other place) Augus	st 18,	Oc. Location - City or Town, State
Provision Middled Examiner 23a. Part . Enter the disease, or complications that casked the death. Do not enter the mode of prings, such as cardiac or respiratory arrest. Approximate and Death of the disease, or complications that casked the death. Do not enter the mode of prings, such as cardiac or respiratory arrest. Approximate and Death of the disease or condition and disease or condition and disease or condition and disease or condition. At her oscillatory of the disease of case of the diseas	Ë	Para Para Para Para Para Para Para Para		*4 □ Donation 5 □ Other (Specify,	Cemerery	2005		ilver Spring, MD
Physician Physician Physician Milectical Exhaminer The decided Exha	Bal	Depar Impo any ir		21. Signature of Formaral Service Lines	$\begin{bmatrix} B \\ B \end{bmatrix}$	2. Name and Address of Facility KOD ethesda-Chevy Chas ethesda Maryland	ert A. Pi	umphrey Funeral Home/ 7557 Wisconsin Avenue
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Wanner of Death 12 1 1 1 1 1 1 1 1 1		/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	a. Atheroscleroti Due to (or as a consequence of): b. Due to (or as a consequence of): c.			Interval Between Onset and Death
25. Was case referred to medical syaminer? 26. Place of Death (Check only one) 27. Wanner of Death 28. Date of Injury 29. Date signed (Month, Day, Year) 29. Date	9289	ficate be physici s the bu			d			
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Wanner of Death 12 1 1 1 1 1 1 1 1 1	.O. Box	the death certi by the attending ached for use a	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐			
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Wanner of Death 12 1 1 1 1 1 1 1 1 1	rds, P	quires that in signed build be det	by	Part II. Other significant conditions co	ntributing to death but not resulting in the i	underlying cause given in Part I.		
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The property of the property o	/ita	cien; ertific ector,	a	examiner?			(Check only one)	
1 Natural 2 Accident 3 Suicide 4 Homicide 4 Ho	of	> .01 0	H-	12 165 2 100	1 Inpatient 2 EH/Outpatie	TIL 3 DOA 4 Nursing Ho		
286. Location (Street and Number or Rural Route Number, City or Town, State) 287. Could not be determined a location of the cause (s) and manner as stated. Check only one) 288. Place of Injury - At home, farm, street, factory, office city or Town, State) 289. Certifier (Check only one) 290. Signature and title of certifier and manner stated. 291. Certifier (Check only one) 292. License number (293. Date signed (Month, Day, Year)) 293. Name and address of person who completed cause of death (Nem 23a) (Type, Print) Patricia Tomsko Nay, M.D. 11119 Rockville Pike, #G-100, Rockville, Maryland 20852		ling F	on	1 X Natural 5 ☐ Pending			28d. Describe how	rinjury occurred
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 15, 2005 30. Name and address of person who completed cause of death them 23a) (Type, Print) Patricia Tomsko Nay, M.D. 11119 Rockville Pike, #G-100, Rockville, Maryland 20852	isio	death death ctor: y the	licat	3 Suicide 6 Could not be	28e Place of Injury - At home farm st		28f. Location (Stre	et and Number or Rural Route Number
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 15, 2005 30. Name and address of person who completed cause of death them 23a) (Type, Print) Patricia Tomsko Nay, M.D. 11119 Rockville Pike, #G-100, Rockville, Maryland 20852	<u>></u>	i Sir fe	ertif	4 - Homicide determined	building, etc. (Specify)	noot, ractory, office		
30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) Patricia Tomsko Nay, M.D. 11119 Rockville Pike, #G-100, Rockville, Maryland 20852		a Hospite 24 hours a Funere etely fille		29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of my knowledge, dea iner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, evestigation, in my opinion, death occurr	and due to the cau red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) Patricia Tomsko Nay, M.D. 11119 Rockville Pike, #G-100, Rockville, Maryland 20852		Fo the within Fo the	Me	29b. Signature and title of certifier	1 1- 1	29c. License number	290	d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death them 23a) (Type, Print) Patricia Tomsko Nay, M.D. 11119 Rockville Pike, #G-100, Rockville, Maryland 20852		- > P O		I Holines To	make Man Min	D51916	Α.	ugust 15 2005
Patricia Tomsko Nay, M.D. 11119 Rockville Pike, #G-100, Rockville, Maryland 20852	1	1/2		30. Name and address of person who c	ompleted cause of death (frem 23a) (Type		A	ugust 17, 2007
	1					•	00, Rocky	ville. Marvland 20852
		Sta	ate	31. Date filed (Month, Day, Year)				

			1 - For State Registrar	State of M	larylan	d / Depa	artment rtificate	t of He	ealth a		ntal Hygi	ene g. No 20 (15	27221	
	Physici	an	Decedent's Name (First, Middle,	Last)						2.	Date of Death Month	1	Year	3. Time of Death	
	/Medic	al	4a. Facility Name (If not institution,	Albert		0	4h Cihi	Town or	Location of			17, 20	05	8:45 PM M	_
	Examin	er		alth of Bet		.	46. City,		Bethes					gomery	
	Funeral		5. Social Security Number		ge (In yrs.	last birthday)	If Under Months		If Under 2 Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day,	Year)	9. Birthi	place (State or Foreign ntry)	
	Director		577-46-8523 Usual Residence of Decedent	143401 2 2 1	89	Yrs.				No	ovember 2	1, 1915		Cuba	_
	within 72 hours after deeth with the Maryland ene. than "natural", or itams 23s or 28s-f ehow ha Madical Examinar must be midlisd at	_	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits	
	28a-f	ecto	Maryland Mon	ntgomery			10f. Žip		vy_Ch	ase	10	g. Citizen of W	hat Cour	1 ☐ Yes 2 🛣 No	_
	h with	a Di		Leland Stre	et			0000	20815	5				States	
	tams (uner	11. Marital Status	12. Was Deceden	t Ever in U.	.S. 13.	Was Deced f Yes, spec	lent of His			/ Yes or No- an, etc.)	14. Race		can Indian,	_
36	irs afte	by Funeral Director	1 ☐ Never Married 2 🕅 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 □ Yes 2 X If Yes, Give Year or Dates:			1 🛚 Yes 2	2□ No	Specify:	C1		Specify:		TT1- 1 A -	
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at ance.	Completed	15. Decedent' (Specify only highest			16a. Dece	kind of wor	k done di	urina most	of working	oan 1	6b. Kind of Bus	iness/In	White dustry	
121	within ene. than	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	e retired)				0-16		3 1	
<u>d</u> 2	e filed I Hygi other	Be Co	17. Father's Name (First, Middle, L	ast)			Jphols				irst, Middle, M	Seli Seliden Sumame		loyed	_
ylar	Menta Menta arked atic ev	To B		Leopoldo So	to						Maria	1/ Unkno	wn		
Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationsh			I						City or Town, S		•	
ē,	s 1 and f Heal		Maria P. Soto/ 1 20a. Method of Disposition		1 ~	lace of Dispo emetery, crer	sition (Nam	ne of	:	et Ch	evy Cha	ase, Maj Oc. Location - C	tyla:	nd 20815 own, State	
Baltimore,	Pege ment c ent: If ury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		• <i>C</i> .	Sate of Heav	en Ce	emete	rv	Augus 19, 2	005 s	Silver S	Spri	ng, Maryla	nd
Balt	permit. Depart Import any inj		21. Signature of Funeral Service L	icensee		Be	Name and	d Address	s of Facility	Rober Chase	t A. P	umphrey 7557 Wi	Fur	neral Home/ nsin Avenue	1
			23a. Part1. Enter the disease, on	Septent cause	M003 od the death	שם ככי	ernesc	ia. M	larvia	ina zu	814-35	U1		Approximate	_
1	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	nny one cause on each Prost		ancer								Interval Between Onset and Death	
1	/Medical Examiner		resulting in death)	Due to (or a									1		_
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	ocuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.											
,092	ate be executed hysicien and he burial-transit	cal Ex	resulting in death) Last	Due to (or a	s a consequ	uence of):							Į		
687	ificate g phys as the			d											_
Вох	thet the death certifica ed by the ettending ph detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome			Ectopic pre	egnancy				23d. Date		,	
0.	he dez	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of de	eath 5	Other (spi	ecity)				Mont	n	Day Year	
Ω.	requires thet the leen signed by th hould be detache	y Ph	Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use contrit	oute to t	ne cause of death?	
ord	w require been sig should b									_ [1 🗆 Ye	s 2⊠No 3	B ☐ Prot	ably 4 Unknown	
of Vital Records,	e law hes b	Completed								_	24a. Was an autopsy	pr	ere auto or to co ath?	psy findings available mpletion of cause of	
tai		4	25. Was case referred to medical						Of Disease	of Dooth (C	1 Yes 2	X No 1 €		2 No	
Ť.	2 w =	To B	examiner? 1 ☐ Yes 2∭ No	Hospital: 1 ☐ Inpat	tient 2	ER/Outpatier	it 3 DO	A Othe				nce 6 ∐Othe	(Specif	(y)	7
	ing Phy I. After thi funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inj (Month, D	jury ay Year)	28b. Time of Injury		8c. Injury Work	7	- 1	. Describe how	w injury occurre	d		_
Division	Attending r death. ctor: After by the fune	Certification;	2 Accident investig. 3 Suicide 6 Could n	ot be 28e. Place of Ir	njury - At ho	ome, farm, str	eet, factory		es 2 □ N		Location (Str	eet and Number	or Rura	il Route Number.	
ă	rs afte	Cert	4 Hornicide	building, e	atc. (Specify						City or Town,	,			
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 ☑ Certifying (Check only one) 2 ☐ Medical E	Physician: To the bes examiner: On the basis and manner s	t of my kno of examina tated.	wledge, death tion and/or in	occurred a vestigation,	at the time in my op	e, date and inion, death	place, and h occurred a	due to the ca at the time, da	use(s) and man te and place, ar	ner as s	tated. o the cause(s)	
	To the vithin 2 To the complet	ž	29b. Signature and title of certifier	7 0		·		. License			29	d. Date signed	(Month,	Day, Year)	
	10		20 Name and address of as		ا ر ما	•		000	571	14		Augu	st]	8, 2005	_
8	50		30. Name and address of person was Truong Bao, M.D				·	a. M	arv1a	nd 20	817-35	3.2			
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	iture					<u> </u>				
	Regist	dl	AUG	1 9 2005	180818	1 15	Ligar	20							

				State of Marylar								-	
			1 - For State Registrar	otato or marytar		tificate						2005	27222
	Dhusiai		Decedent's Name (First, Middle, Last							2. Date of Dea Month			3. Time of Death
13	Physici /Medic		JAMES EVERETY	THAXTON						August	12	200	
	Examin	ner	4a. Facility Name (If not institution, give			_	. 1	Location of	of Death		4c.	County of Dear	
	- Funeral		Saint Agnes He 5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	If Under		If Under		8. Date of Birth	1	9. Bin	thplace (State or Foreign
	Director		217.24.3899	M 2□ F 76	Yrs.	Months	Days	Hours	Min.	(Month, Day 06 · 08 ·	1920	Co	VA
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Many I she	tor	MD NA	BAL	MORE								1 ☑ Yes 2 ☐ No
	or 28e	Funeral Director	10e. Street and Number			10f. Zip	Code			1	0g. Citi	izen of What Co	ountry?
	ath w	ral	2900 WINCHESTE				21214				· Ţ	USA	
	ter de	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 □ No	.S. 13. \	Nas Deced f Yes, spec	ent of His rfy Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
036	ours af		3 ∰Widowed 4 Divorced	If Yes, Give Year or Dates:		I□Yes 2	No Mo	Specify:				Specify: BU	ACK
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or itema 23a or 28e-f show the Medical Exacilier inval be codified at	Completed by	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deced	ient's Usua kind of wor DO NOT us	l Occupa k done d	ition Turing most	t of worki	ng	16b. Ki	ind of Business	Industry
121	within lane. then	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)	FORE!		e retired)				251	HLEHEN) STEEL
	Hygi other	Be Co	17. Father's Name (First, Middle, Last)	10/14	· UKE	INTIV		18. Mothe	r's Name	(First, Middle,			1 SIEEL
/lan	ould be in Mental I warked o	To B	LAWRENCE THAXTO	N			1	ELIZA	BET	H BARI	KSD	ALE	
Maryland	and and ls m		19a. Informant's Name/Relationship (T)	1	_					I Route Number			Zip Code)
	1 end Health em 27 ther tr		PATRICIA THAYTON 20a. Method of Disposition	(DAUGHTER)	2400 Place of Dispo			ER E	51,	BALTO.		21216 ecation - City or	Tourn State
Baltimore,	Pages nent of int: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	semetery, cren	natory or ot	her place		a 10				
altir	permit. Pag Department Importent: f eny Injury o		21. Signature of Funeral Service Licens		RRISON	Name and	Addres	s of Facilit	8.18	.00	STO	ugs m	ius, Mo
ä	Departing Department of the police.		>2 augh_		51	51 BAU	10. N	areen Iati: P	JE FI	UNERAL BALTO. A	10 L	21229	
**			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the deat ne cause on each line.	h. Do not ente	er the mode	of dying	, such as	cardiac c	r respiratory arr	est,		Approximate Interval Between
12	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Interventr	cular	hen	on	hage.					Onset and Death
	Examiner			Due to (or as a conseq	uence of);			J					
		Jer	Sequentially list conditions, if any, leading to immediate	b. hyperlensus Due to (or as a conseq									years
	nd nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
760,	te be executed ysicien and le burial-transit	I Ex	resulting in death) Last	Due to (or as a conseq	uence of);								
687	that the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit	dlcal		d									
Box (The law requires that the death certifica lie hes been signed by the ettending ph age 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna							2	23d. Date of del	ivery
-	ed for	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown		lEctopic pre] Other (spe						Month	Day Year
P.0	d by Il	Phy	9 ☐ Unknown Part II. Other significant conditions co			4-3-5				00- Bid 1-1			
ds,	signe d be c	d by	Fait II. Other significant conditions (c)	ninouting to death out not res	uiting in the ur	ndenying ca	iuse give	n in Part I.				Se contribute to ☐ No 3 ☐ Pr	the cause of death?
Records,	w requires (been signe should be	Completed								24a. Was a			
Re	The ta te hes age 2	omp								autops	y ned2	death?	topsy findings available completion of cause of
Vital		BeC	25. Was case referred to medical examiner?					26. Place	of Death	(Check only on	2 No e)	1 Yes	2 No
of V	ding Physician: h. After this certifici funeral director, i	P	1 ☐ Yes 2 ☑ No		ER/Outpatien			4 🗀 1901		ne 5□ Reside			cify)
ou	or After	Certification:	27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	Bc. Injury Work	at ? ′es 2 □ h		28d. Describe ho	ow injury	y occurred	
Division	Atten r deal octor:	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, stre			63 2		28f. Location (St	reet and	d Number or Ru	ıral Route Number,
Ö	s afte	Cert	4 ☐ Homicide determined	building, etc. (Specif	Y)					City or Towr	n, State,)	
	To the Hospitef or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	ical	Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	wledge, death	occurred a	it the time	e, date and	d place, a	and due to the ca	ause(s)	and manner as	stated.
	o the ithin 2 o the	Medical	one) 29b. Signature and title of certifier	and manner stated.			License					e signed (Monti	
	F 3 F 8		mmaka	1 mm			P170						
	(0		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type,		T 1 TL	<i>JUI</i>		+	ug il.	s+12,7	2005
	Œ		Nareesa Mohamo			ve ,	Ba 1	hmo	re,	MD 2	122	9	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture				*				
	riegisti	201	AUG 1 9 2005	place st.	FATE TO	3							

JAMES

THAYTON,

Registrar

State

DHMH 17 Rev 1/2001

AUG 1 9 2005

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

			For State	State of Marylai		artment of F ertificate of		Mental Hy	00	0 = 1	07001
			Registrar 1. Decedent's Name (First, Middle, Las	t)		Timeate or	Dealii	2. Date of De	Reg. No.	Ub.	3. Time of Death
	Physicia /Medic			B. Ward				Augus	Day	2005	2050 M
	Examin		4a. Facility Name (If not institution, give	/	1	4b. City, Town, o	r Location of Deatl		4c, Cou	nty of Death	
			5. Social Security Number 6. So	egional -	osp. Tal	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	Prin		eorges
Н	Funeral Director			7. Age (In yrs		Months Days	Hours Min.		Year) 194	Coun	lace (State or Foreign try) York
	pug .		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or L	ocation					0d. Inside City Limits
	Maryla faho	lor	Maryland N/A		,,	Balti	moro				1 XYes 2 ☐ No
	h the	Director	10e. Street and Number			10f. Zip Code	niore	T	10g. Citizen	of What Coun	try?
	ath wil		10 Sunny Meado	w Court, Ap		21	224		USA		
	ter de Itams Irer	Funeral	 Marital Status Married 2 Married 	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ☑ No	J.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	Specify Yes or No to Rican, etc.)		Race - Americ Black, White, o	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f ahow Ita M. Jical Exc. pit et i. uat be notified al	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give The Year or Dates:		1 ☐ Yes 2 X No	Specify:		Spe	cify: Wh	ite
5-0	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of wor	rking	16b. Kind of	Business/Ind	dustry
212	filed within Hygiene. othar than ant, I're M	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		spatcher			Cab	Compa	anv
	be filed Ital Hygi Id other Bvant, II	Be C	17. Father's Name (First, Middle, Last)	-		, p. 0. 0 0 11 0 1		me (First, Middle			any
Maryland	should the marked the marked umarics	To	Jerry Ward	S. D. Orien	101 14			ley Gi			
Ma	and 2 sho salth and n 27 ls ma		19a. Informant's Name/Relationship (Carmelita A. Malia			ling Address (Street Elmridge		Baltimo			Code)
ore,	es 1 and 2 of Health fitsm 27		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □	20b.	Place of Disp	oosition (Name of omatory or other place		Date	•	n - City or To	wn, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Items 23e or 28e-1 ahow any injury or other traumatic avant, I'm Modical Examinet or all be notified at anone.	1	* 4 □ Donation 5 □ Other (Specify) Me		ematory,				imore,	MD
Baj	permit. Pages 1 an Department of Heal Importent: If itam 2 any injury or othar once.		21. Signature of Funeral Service Licen	corchik	Ć	remation 299 Freder	Society ick Road	of MD, Balti	Inc. nore, N	1D 2122	28
	*	j.	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea							Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Athenosch	ereti	c CArdo	ovascu	law H	east I	is enz	e
	Examiner .		f	Due to (or as a conse	quence of):						
	p #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):						
_	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):					-	
68760	ficate be executed physician and is the burial-transit	edical E		d				_			
			IF FEMALE:			-					
Вох	that the death certif ed by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of	al death 3	☐Ectopic pregnanc	у			Date of delive Month	ry Day Year
P.O.	the de	hysic	1 Yes 2 No 9 Unknown	9 Unknown	dealli 5						
	res that the de signed by the a be detached f	by P	Part II. Other significant conditions of	ontributing to death but not re	sulting in the	underlying cause giv	ven in Part I.				e cause of death?
ord	w require been si should t	eted	obesity								ably 4 Unknown
of Vital Records,	e la has	Completed							psy ormed?	prior to con death?	psy findings available inpletion of cause of
ita		a	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only	2t No	1 🗆 Yes	2 No
Į (si ib	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpation	ent 3 DOA Ott	ner: 4 🗌 Nursing H	Home 5 ☐ Res	idence 6 🗆 (Other (Specify	1)
o uc	Jing P	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo	ry at rk? Yes 2 □ No	28d. Describe	how injury occ	curred	
Division	l or Attanding after death. Director: Afte I in by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At			163 2 140	28f. Location (Street and Nu	m <i>ber</i> o <i>r Rur</i> a	l Route Number,
Ö	Hospitel or A tours after Funaral Director Funaral Director tely filled in by	O	4 _ nomicide	building, etc. (Spec	:iny)			City of 16	wn, State)		
	To the Hospitel or Attanding Phwithin 24 hours after death. To the Funaral Director: Atter th completely filled in by the funeral	ledicai	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Examone)	ysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, dea nation and/or	ath occurred at the ti investigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)
	To the I within 2. To the I complet	M	29b. Signature and title of certifier	11 -+-	>-	29c. Licens	-		29d. Date sig	ned (Month,	Day, Year)
,	1		30. Name and address of person who	gy-SW S	<i>₩</i>		55921		A Lighty	it 15/	2005
1	ر		SALVADOV Sylvat	Ter, 3001 /60	on 23a) (Type	(DVI-v	e, cha	verl	May	land	J
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sigi	nature			01	0		
	Regist	rair	AUG 1 9	2005 Mayers	K	Beach)					

1. Consider Name (First, Addison, Last) Roger W. Wyatt S. 2005 S. 1.45 A. M.				For State Registrar	State of Maryland	•	artment of Healt			ne . 2005	27225
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Baltimore Washington Medical Center Common		_							August .		5:45A M
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Supplementary Supplementar	6 1-1-1 1∰1.	Euporal	8				If Under 1 Year If Un		8. Date of Birth		Birthplace (State or Foreign
Total States Total Country Total Post				212-40-3135	^{M 2□F} 62	Yrs.	Months Days Hou	ırs Min.	JUL 16,	1943 1	Country)
George W. Wyatt 19a. Informant's Name-Relationship (Type, Print) 19b. Mailing Address (Sireet and Number of Purul Route Number. City or Town. State. Zip Code) Pauline D. Wyatt\Wife 29 Gambrills Road Severn, MD 21144 20a. Method of Disposition 1 District 2 Quarterstance 2 Quarter		and w			10c. City. T	own or Lo	cation				10d. Inside City Limits
George W. Wyatt 19a. Informant's Name-Relationship (Type, Print) 19b. Mailing Address (Sireet and Number of Purul Route Number. City or Town. State. Zip Code) Pauline D. Wyatt\Wife 29 Gambrills Road Severn, MD 21144 20a. Method of Disposition 1 District 2 Quarterstance 2 Quarter		Maryli f sho	lor								
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Physician / Medical Examiner Physic	ב ב	of He		i	moval from State	of Dispo	sition (Name of matory or other place)	Da			or Town, State
Physician / Medical Examiner Physic		Pag tmenf tant: jury c		`4 □Donation 5 □ Other (Specify)	Metro				05	<u>Baltimo</u>	re, MD
Physician / Medical Examiner Physic	ם מ	Depar Depar Impor any in		Elust-Ric	lk.	22	Name and Address of Facemation So	acility Ciety o	of MD, Ir	nc.	
Physician (Medical Examiner) Required the Cause (Final disease or condition resulting in death) Required the Cause (Final disease or condition resulting in death) Required the Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or				23a. Part1. Enter the disease, or complic	ations that caused the death. [Do not ent	299 Frederic er the mode of dying, such	K Road n as cardiac or	Baltimor respiratory arrest	e, MD 2	Approximate
February February		Physician		Immediate Cause (Final	ΛH and it		Anem	ia			Onset and Death
Sequentially list conditions Sequentially list conditions		/Medical		resulting in death)	Due to (or as a consequen	ce of):					6 70.004
Cause Diseases of injury feath) Last Cause Diseases of injury feath) Last Cause Diseases of injury feath Last Cause Diseases of injury feath Last Cause Diseases of injury feath Last Cause Diseases of injury feath Last Cause Diseases of injury feath Last Cause Diseases of injury feath Last Cause Diseases of injur		Examiner	-	Sequentially list conditions, b.	Due to /es as a consequen	aa af):					
FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 1 Yes 2 No 3 Probably 4 Unknown 2 And 1		nsit	nine	Cause (Disease or injury	Due to tor as a consequent	Ce OI).					
IFFEMALE: 23b. Was deceded pregnant in the past 12 months? 1 Ves 2 No 3 Probably 4 Unknown 23d. Date of delivery Month Day Year 1 Ves 2 No 3 Probably 4 Unknown 24a. Was a performed of pergnancy 1 Ves 2 No 3 Probably 4 Unknown 24a. Was a performed of pergnancy 1 Ves 2 No 3 Probably 4 Unknown 24a. Was a performed of pergnancy 1 Ves 2 No 3 Probably 4 Unknown 24a. Was a performed of pergnancy 1 Ves 2 No 3 Probably 4 Unknown 24a. Was a performed of pergnancy 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy prior to completion of cause of death? Ves 2 V	5	execun and ial-tra	Ехаі		Due to (or as a consequen	ce of):					
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## do not be a support of the course of the	ò	attenc for us	cian/	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de	ath 3[
25. Was case referred to medical examiner? 1	į	the day the ached	ysic				Other (Speeday)				
25. Was case referred to medical examiner? 1	'n	s that		Part II. Other significant conditions cont	ributing to death but not resultin	g in the u	nderlying cause given in P	art I.	23e. Did tobac	cco use contribute	e to the cause of death?
25. Was case referred to medical examiner? 1	Š	equire sen siç ould b							1 Tes	2 □ No 3 □	Probably 4 Unknown
25. Was case referred to medical examiner? 1	ב ב	law r	npie						autopsy	prior	to completion of cause of
1 Yes 2 Ye	5	r: The							1 ☐ Yes 2 ☐	No 1 □ Y	'es 2□ No
28a. Date of Injury - At home, farm, street, factory, office 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury - At home, farm, street, factory, office 28b. Time of Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury - At home, farm, street, factory, office 28c. Place of Injury - At home, farm, street, factory, office 28c. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Describe how injury occurred 28d. Describe ho	X	alciar	8	examiner?	ospital: 1 Alphatient 2 1 5 B	Outpation	Other			o 6 DOthor /6	· · · · · · · · · · · · · · · · · · ·
State Stat	5	g Phy er this eral d	-	27. Manper of Death		b. Time o	28c. Injury at				pecnyj
3 Suicide 4 Homicide 4	2	andlin ath: or: Aft	atio	2 Accident investigation	(World, Day Fear)	пјиту		2 □No			
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40c. 21061 31. Date filled (Month, Day, Year) 31. Date filled (Month, Day, Year) 32 Date filled (Month, Day, Year) 33. Date filled (Month, Day, Year) 34. Date filled (Month, Day, Year) 35. Registrar's Signature	<u>"</u>	or Attr fter de iiracte n by ti	rtiflo	determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office	28			Rural Route Number,
(Check only one) Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	3	spital ours a laral Diffilled i		29a Certifier 19 Certifying Physi	cian: To the best of my knowle	dae dest	occurred at the time, date	e and place an	ad due to the caus	ca/s) and manner	as stated
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 18, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yudhish Maruam 305 Hospital Drive, Gless Burnie MD. 21061		na Hos na Fun letely	dica	(Check only 2 Medical Examina	er: On the basis of examination	and/or in	vestigation, in my opinion,	death occurred	d at the time, date	and place, and	due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holdish Markan 305 Hospital Drive, Gless Burnie MD. 21061		To the To the Comp	Me	29b. Signature and title of certifier			29c. License numb	per	29d	. Date signed (Mo	onth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yudhish Maryan 305 Hospital Drive, Gless Burnie 13. Date filed (Month, Day, Mearly 6, 2005 32. Registras's Signature).		~		ymanh	an M.D		D395	500	A	ugust	18, 2005
State 31. Date filed (Month, Day, Mearly of 2005 32. Registrar's Signature)		12		30. Name and address of person who con	npleted cause of death (Item 23	a) (Type,	Hachstal	Drive	Gless	Bum	ie
ALIG M COUL PROBLEM FOR				31. Date filed (Month, Day, Wear)	00 32. Registrar's Signature	100	Corner			WD	. 21001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryland / Department of Health and N	иенкаі пус	gione		
<u></u>		Certificate of Death	F	Reg. No.2	0.5	77226
		1. Decedent's Name (First, Middle, Last)	2. Dete of Dea	ath Day	Year	3. Time of Death
	Physician	Julia B. Williams	AUG	18 30		7:55P
	/Medical Examiner	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Li		7		
		Lorien Nursing Center BEL AIR		HAR	FORI	0
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birti (Month, Day			e (State or Foreign
	Director	216-24-9186 10 M 20 F 77 Yrs. Months Days Hours Min.	3-25	-28	N/10	York
-	υ	Usual Residence of Decedent			7. (4.5)	101
	nylan how	10a. State 10b. County 10c. City, Town or Location			10d.	Inside City Limits
	e-f-	MD HARFORD JODGE				1 □ Yes 2 No
	death with the Maryland ims 23e or 28e-f show if must be notified at	10e. Street and Number		10g. Citizen of V	Vhat Country	?
	h wi	319 Janoa (ROSSINA (+ 21085		UE	SA	
		11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No-	14. Rac	e - American	
0	or ha	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:	r noan, otc.,			
5-0020	72 hours after naturel; or its feal Examine sted by Fu	3 (Widowed 4 □ Divorced Year or Dates:		Specify	whi	re,
5.0	"naturel", "naturel", ideted by	15. Decedent's Educetion (Specify only highest grade completed) (Give kind of work done during most of work life. Decedent's Usual Occupation (Give kind of work done during most of work life. Do NOT use retired)	kina	16b. Kind of Bu	ısiness/Indus	try
्रद्रह	an " and "	Elementary/Secondary (0-12) College (1-4or 5+)		• 1	0 4	6
32	Soin T. CO	12 4 Lab lech		Univ.	0+111	12
₹₽	be filed within 72 ho tital Hygiene. d other than "nature event, the Medical Be Completed	17. Father's Name (First, Middle Last) 18. Mother's Name	e (First, Middle,	Maiden Surnam	10)	
1	Ment Ment Ment Ment Ment Ment Ment Ment	Thomas Hnderson Lillie	an Gr	oth.		
ar	permit. Pagas 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce. To Be Compi	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	ra / Route Numbe	r, City or Town,	State, Zip Co	ode)
3 ≥	and alth	John Williams 710 Thornwood Ct.	Tows	son M	10 21	2860.
Selliams Baltimore, M	othern other	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location -	City or Town	, State
3 5	Page ant cant ry or	1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify)	2-10-05	FORF	EST	HILLME
3 #	permit. Departm Importal any inju		au cu	10/0	21720	1
°Š ä	per imp any any	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility	T. MORE	e, MD	2(20)	7
ے ا		Mully y Jamony Exans FUNERAL CH	APEL,88	DO HARI	FORD K	O.
-		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart tailure. List only one cause on each line.	or respiratory an	1651,	Ć in O	pproximate terval Between nset and Death
	Physician /Medical	Immediate Cause (Final				
	Examiner	disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT				
	1	Due to (or as a consequence ot):			1	
w.	icate be executed physician and s the burial-transit	b			i	
12	ficate be executed physician and as the burial-transit edical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.				
68760,	be e ician buria	cause. Enter Underlying Cause (Disease or injury				
87	phys the	that initiated events resulting in death) Last Due to (or as a consequence of):			i	
×		d			i	
Box	attending for use a					
P.O.	the street	Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld te	obacco use cor	ntribute to th	e cause of death?
9.	d by Setac	CDRONARY ARTERY DISEASE, ATRIAL FIBRILLATION	1□ 1	es 2□ No	3 Probab	ly 4 Unknown
5,	igne be c	CONTROLLER T SISETISE, IT KING PIBRICENTION				
0	5 2 D			A 1 111	0.11	and the street
ō		HUPERTENSION CANGESTINE HEART RAVINE	24a. Was a perfor	an autopsy med?	availa	autopsy findings ble prior to
ecor	law requires that the death cer as been signed by the attendin 2 should be detached for use pleted by Physician/N	HYPERTENSION, CONGESTIVE HEART FAILURE	24a. Was a perfor	an autopsy med?	availa	ble prior to letion of cause
l Recor	The law requate has beer page 2 shou		24a. Was a perfor	med?	availa comp of dea	ble prior to letion of cause
ital Recor	ian: The law requires that tha death cert rificate has been signed by the attending stor, page 2 should be detached for use a Se Completed by Physician/M	DIABETES MELLITUS, HYPOTHYROIDISM 25. Was cese referred to medical 26. Place of Death	perfor 1 □ Y	med?	availa comp of dea	ble prior to letion of cause th?
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Division of Vital Recor	To the Hospital or Attending Physician: The law req within 24 hours aftar death. To the Funeral Director: Attar this cardificate has been completaly filled in by the funeral director, page 2 shou Medical Certification: To Be Complete	25. Was case referred to medical examiner? 1	perfor 1 Y th (Check only or ome 5 Resid 28d. Describe h 28f. Location (S City or Tow and due to the c red at the time, d	red? Tes 2 No Tes 3 No Tes 4 No Tes 4 No Tes 4 No Tes 5 No Tes 5 No Tes 6 □ Other Tes 6 □ Other Tes 6 □ Other Tes 7 No Tes 7 No Tes 8 No Tes 8 No Tes 8 No Tes 8 No Tes 9 No Tes	availa composition of dea	ble prior to letton of cause th? es 2□ No oute Number, et cause(s)
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Division of Vital Recor	To the Hospital or Attending Physician: The law req within 24 hours aftar death. To the Funeral Director: Aftar this cartificate has been completally filled in by the funeral director, page 2 shou SMedical Certification: To Be Complete	25. Was case referred to medical examiner? 1	perfor 1 Y th (Check only or ome 5 Resid 28d. Describe h 28f. Location (S City or Tow and due to the cred at the time, d	rmed? Tes 2 No Tes 3 No Tes 4 No Tes 4 No Tes 4 No Tes 5 No Tes 5 No Tes 6 Other Tes 6 Other Tes 6 Other Tes 6 Other Tes 7 No Tes 7 N	availa comport of dea to the comport of dea to the comport of dea to the comport of the comport	ble prior to letton of cause th? es 2□ No oute Number, et cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 State	partment of Health and Mental	
			1. Decedent's Name (First, Middle, Last 29d PER PHY C846	ertificate of Death 8/19/05 JH 2. Date of	11-31-201-0-0-0-1
	Physici			Month	Day Year
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	st 6, 2005 2:20 P M
1	LXamii	٠.	Althea Woodland Nursing Home	Silver Spring	Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		of Birth 9. Birthplace (State or Foreign Country)
	Director		049-16-2632 1□M 2XF 94 Yrs.	June	30, 1911 Augusta, GA
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation	10d. Inside City Limits
	f sho	ō	Maryland Montgomery Silver S		1 ☐ Yes 2 ☑ No
	28a	rec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	N with		1000 Daleview Drive	20901	U.S.A.
	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f show than "hadleal Examinar nasal bu notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.	or No- 14. Race - American Indian,
9	or Its	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No	1 ☐ Yes 2 🕅 No Specify:	Black, White, etc. Specify:
215-0036	ural',	d b	3 월 Widowed 4 □ Divorced Year or Dates:		Black
15-	"nati	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given life	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
212	within	шо	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	Own Home
9	Hygi other	a	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mi	
<u>la</u>	Mental Mental rked rlc ev	To B	Henry Lamkin	Anna (Unkno	own)
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "iraumatic event, the Me.		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural Route N	umber, City or Town, State, Zip Code)
	and sealth n 27 m			Silver Brook Way., Bowi	
ore	Jes 1 If Iter or oth		20a. Method of Disposition 20b. Place of Disposition 1 Burial 2 Cremation 3 Removal from State	ematory or other place)	20c. Location - City or Town, State
Ë	tment tent: jury		'4 Donation 5 Other (Specify) Church	Cemetery 8/10/03	Cumberland, VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If tem 27 is marked other than "natural", or Itema 23a or 28a-f show arry high or other traumatic event, the Medical Examinat meat by notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Bland-Reid Funeral Hom	
	402 40		23a. Part1. Enter the disease, or complications that caused the death. Do not e		e, VA 23901 ory arrest. Approximate
			shock, or heart failure. List only one cause on each line.		Interval Between
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	erotic Cavellovascula	years years
	Examiner				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying. Due to (or as a consequence of):		
4	ocuted nd transi	Examlner	cause. Enter Underlying Cause (Disease or injury that initiated events c.		
90,	oe execian a	EX	resulting in death) Last Due to (or as a consequence of):		
68760,	licate be executed physician and s the burial-transit	edical	d		
	eath certifi attending I for use as		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Box	that the death cert ed by the attendin detached for use	clar	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)	Month Day Year
0	the d by the achec	hysl	9 ☐ Unknown		
۵.	law requires that the death certit as been signed by the attending 2 should be detached for use a	Completed by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the	arractlying sactor given in taken	Did tobacco use contribute to the cause of death?
ğ	w require been sig should b	ed	Dementa		1 Yes 2 No 3 Probably 4 Unknown
Records,	e law re has be je 2 sho	plet	Osteoponotic Fracture Righ	Tlower FemoR 24a.	Was an 24b. Were autopsy findings available prior to completion of cause of
<u> </u>	The ate h page	Com		1 🗆 Y	performed? death?
Vital	clan: ertific actor,	Be (25. Was case referred to medical examiner?	26. Place of Death (Check of	niy one)
of \	Phyaiclan: this certific ral director,	2	1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time		Residence 6 Other (Specify) ribe how injury occurred
ПО	ling After fune	tlon	1X Natural 5 ☐ Pending (Month, Day Year) Injury		not now injury cocamou
Division	Attending or death.	flca	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s	street, factory, office 28f. Locati	ion (Street and Number or Rural Route Number,
ΟŠ	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)	City o	r Town, State)
	Hospital 24 hours a Funeral I		29a. Certifier 1X Certifying Physician: To the best of my knowledge, de-	ath occurred at the time, date and place, and due to	the cause(s) and manner as stated.
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurred at the t	
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year) 8-19-2005
	\wedge		* Sulling when	1 101852	.55.63.2
	1		30. Name and address of person who completed cause of death (Item 23a) (Typ		
	Sta	te	PAN A. DEVORE MD YLOS QUEENS DUI 31. Date filed (Month, Day, Year) 32. Registrar's Signature	יץ אמינין	
	Registi		AUG 1 2 2005	for the	

DHMH 17 Rev 1/2001

ORIGINAL

Physician

	/Medic	al							Majue	16	200:	
-	Examin	er 	4a. Facility Name (If not institution, give		Chimore		him	Location of Deal	ty	4c. Cou	nty of Dea	
	Funeral Director			ex 7. Age (1. X) M 2 F 87	n yrs. last birtho Yr	Months	1 Year Days	If Under 24 Hrs Hours Min		th 10°, 19	9. Bi	rthplace (State ounter) W Jerse
	2 2	1	Usual Residence of Decedent 10a, State 10b, County	10	Oc. City, Town o	or Location						10d. Inside
	ehov	5										
	8a-1	cto	Maryland N/S		Balt	imore						XXY
	23a or 2	Funeral Director	5506 Roland Avenu	e		10f. Zip		21210		10g. Citizen	of What C	ountry?
036	72 hours after death with the Maryland naturel', or items 23a or 28e-f ehow jisal Evaniner must be notified at	þ	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 TYNo If Yes, Give Year or Dates:	or in U.S.	13. Was Deced If Yes, spec 1 ☐ Yes X	ify Cubar	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	E	Black, Whi	erican Indian ite, etc. lhite
20	72 hc	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. D	ecedent's Usua	il Occupa	tion	rkina	16b. Kind o	Business	/Industry
7	C * 0	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	'ii			uring most of wo	, mig			
7	P S S S	no.		5+		Vice	Pres	ident			Manu	factur
Maryland 21215-0036	should be filed within 72 ho nd Mental Hygiene. marked other then "natu imatic event, tra Medical	To Be C	17. Father's Name (First, Middle, Last) William Henry Wil						me (First, Middle Meht	, Maiden Sun	ame)	
	nd 2 :		19a. Informant's Name/Relationship (Harriett Plaisted	Wilson Wi	fe 55	06 Rola	nd A		ural Route Numb altimore			
altimore,	Page nent o ant: if ury or		20a. Method of Disposition 1XXBurial 2 Cremation 3 4 Donation 5 Other (Specify	Damarral from Cross		crematory or o	ther place	ry 8/2	Date 2/05	Pikes		Mary
Balt	permit. Page Department o Important: if eny injury or once.		21/ ignature of Funeral Service Licer	Wena	k	22. Name an			tchell-Wie Road Balti			
68.60,	Physician be executed attending physician and attending physician and for use as the burial-transit	cal Examiner	23a. Part1. Enter the disease or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	e Ro onsequence of) VLA W C onsequence of)	nal cari	e of dying fail	ma	c or respiratory a	rrest,		Approxit Interval Onset a
P.O. Box 68	thet the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of particles of the companies of the	Fetal death	3 ☐Ectopic pr 5 ☐ Other (sp					Date of de Month	olivery Day
	w requires thet to be a signed by should be detailed	by	Part II. Other significant conditions of	ontributing to death but r	not resulting in the	ne underlying c	ause give	n in Part I.		tobacco use c		o the cause
Cor	w requ	letec							24a. Was			utopsy findin
Vital Records,	hysicien: The law requires th his certificete has been signed I director, page 2 should be de	Completed							auto		prior to death? 1 \(\sum \text{Ye.}	completion
ita	rtific tor,	0	25. Was case referred to medical					26. Place of De	ath (Check only	one)		
	Physicien: this certific ral director,	OB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outp	atient 3 DC	Othe	4 Nursing I	Home 5 ☐ Res	dence 6	Other (Spe	ecify)
Division of	ng P fter t	atlon: T	27. Manner of Death 11 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	ear) 28b. Tin	ne of 2	8c. Injury Work		28d. Describe			
Divis	el or Atte s after de: l Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined			n, street, factory	, office		28f. Location (City or To	Street and Nu wn, State)	mber or F	lural Route N
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									s stated. e to the caus
	Withii To th	M	29b. Signature and title of certifier			290	. License			29d. Date sig	ned (Mon	th, Day, Yea
			Kazi A. a	Zawan i	MD		RES	5-000)	Augu	et 1	6,20
•	10		30. Name and address of person who				C 8 1	TAI S	C BAIT			

ZAMAN, MD

32. Registrer's Signature

1. Decedent's Name (First, Middle, Last)

WILLIAM

HFNRY

WILSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Pikesville Maryland efeld Funeral Home Inc ore, Maryland 21212 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year acco use contribute to the cause of death? s 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No ed? nce 6 Other (Specify) w injury occurred eet and Number or Rural Route Number, State) use(s) and manner as stated. te and place, and due to the cause(s) d. Date signed (Month, Day, Year) August 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE SINAI ORIGINAL

Reg. Ng2 0 0 5

16

Year

2005

Manufacturing

12:00 PM

9. Birthplace (State or Foreign

10d. Inside City Limits XXYes 2 No

New Jersey

2. Date of Death

Month

DHMH 17 Rev 1/2001

State Registrar

KAZI

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Estelle Zaranski Mildred 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Estelle Zaranski 31, 2005 Mildred July 12:21 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, Oct. 7, If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 M 2 TF 228-22-7817 Yrs. Virginia 81 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director VA Westmoreland Montross 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 536 Erins Drive 22520-3514 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipiry or other traumatic event <u>once.</u> Be John Lewis Jenkins Mary Hennage ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank B. Zaranski - Husband 536 Erins Drive Montross, VA 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cometery, crematory or other place)
Historyland Mem. 1 Burial 2 Cremation 3 Removal from State 8-4-05 King George, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) Park Cemetery 22. Name and Address of Facility
Welch Funeral Home 21. Signature of Fureral Service Licens 17546 Kings Hwy Montross, Virginia 23a. P.rrt. E fler the disease, whose discations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final diseas or condition **Physician** Myocardial Infarction resulting in death) /Medical Due to (or as a consequence ot): Examiner Coronary Artery Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transi the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 Yes 2 No Year Month Day 5 Other (specify) 4 Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 □ No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3X DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Attending 1 X Natural 5 Pending investigation 1 🗌 Yes 2 No death. after death Diractor: 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0038026 Aug. 1, 2005 30. Name and address of person who complete ause of death (Item 23a) (Type, Print) Mark King, 5755 MDCedar Lane Columbia, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Virginia Lee Johnson Armitage 2:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hogerstown If Under 1 Year | If Under 24 Hrs. Washington 5. Social Security Number 7. Age (In yrs. last birthday) 76 Yrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 1 F Yrs. Director 175-24-9095 Pennsylvania Feb 5 Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Exactiner must be notified at Maryland Washington 1 ☐ Yes X☐ No Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o 19800 Tranquility Circle 21742 U.S.A. items 23a Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural; or iter 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced traumatic event, the Mudicul 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Human Resources Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wesley Johnston 2 Emma Michaelis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Charles Armitage (son) 4 Hamilton Court Lawrenceville New Jersey 08648 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant View Gardens Aug 12 05 Martinsburg West Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician noxemica disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Bil aterel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner courted infortan use as the burial-transit The law requires that the death certificate be executed Wave Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnam 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2∏ No 1 Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Certification: To 1 Tes 1 Hnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 -Natural 5 Pending 1 Yes 2 No investigation after death Director: death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

within 2 0

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

auc C

Danjeu 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

		ļ	For 1_ State	State of	Marylan		artment of H		nd Mental Hy			
_			Registrar 1. Decedent's Name (First, Middle, Last,)		Cei	lilicate of t	Dealii	2. Date of D	eath ()	5	2 7 2 2 3
	Physici	an			AMDRO	α 			Month	Day	Year	M M
	/Medic Examin		CATHERINE 4a. Facility Name (If not institution, give	street and num	AMBRO	5E	4b. City, Town, or	Location of	AUGUS Death	4c. County	of Death	6:47 p
	Examin	Çı	Frederick Mem	orial	Hospi	tal	Freder	ick		Frede	eric	k
	Funeral		5. Social Security Number 6. Sec	x 7	. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2 Hours		irth (ay, Year)	9. Birtho	place (State or Foreign
	Director		220 10 1004]M 2☐ N F	90	Yrs.			0ct.1	7, 1914		/l'and
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation				1	0d. Inside City Limits
	Mary -f sho	ţō	Maryland Freder	ick			Keymar					1 ☐ Yes 2 🕍 No
	r 28e	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Cour	ntry?
	th wit	ai D	11403 Cash Smith	Rd.			2	1757		U	.S.A.	
	r dea	Funerai	11. Marital Status	12. Was Deced Armed Ford	es?	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Orig in, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Rac Blac	e - Americ ck, White,	ean Indian, etc.
9	tiled within 72 hours after death with the Maryland Hygiene. kther then "neturel", or Items 23a or 28e-f show ent, the Madical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat	_		1 □ Yes 2 🗷 No	Specify:		Specify	/: Wi	nite
ş	thour	Completed by	15. Decedent's Edu	ıcation		16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu		
ر 15	nin 72 " ne Medii	piet	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4	4or 5+)	(Give	kind of work done of DO NOT use retired	during most	of working			,
7	d with	Com	7	0011090 (1			homemak				home	2
Maryland 21215-0036	m - 0 5	Be	17. Father's Name (First, Middle, Last)						's Name (First, Middle	F1 61	,	
<u>\S</u>		2	Charles U. Cannon	Dian.		405 44-17-			na Catheri			0.41
<u>a</u>	12 g h ar 7 le treu		19a. Informant's Name/Relationship (T) Pauline Bell/daugh				Dorcus		ror Rural Route Numi Woodsbore			(Code)
	1 and Health tem 27		20a. Method of Disposition	1001	20b. P	lace of Dispo	sition (Name of	I	Date	20c. Location -		own, State
٥	Pages nent of I ant: If its ary or o		1X Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)		tate i		natory`or other plac n Mem. Gar		3/8/2005	Freder	ick.	MD
Baitimore,	permit. Pages 1 and Department of Healt Importent: If item 2 eny injury or other once.		21. Sig ur of Fyderal Service Licens		50 /				Hartzler		•	
ñ	Deg m o		affarine .	XMIZ	Her	1	104 S. Ma	in St.	Woodsb	oro, MD	21798	}
	Ę	00000	23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that can ne cause on ea	used the deatl ch line.	n. Do not ent	er the mode of dyin	g, such as c	cardiac or respiratory	arrest,	. [Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Acui	EH	1 YOCA	ROIAL	INFA	ARCTION	/	المر	Onset and Death
	/Medical- Examiner		resulting in death)	Due to (o	r as a conseq				1	- Dave		
	ZXditiiioi	7.	Sequentially list conditions,	b	r as a conseq	nence of).			Je di	at		
	rted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (0	. 23 a consoq	aciioc 51,.		8	- 12 ·	9		
,	execun and ial-tra	Еха	that initiated events resulting in death) Last	Due to (o	r as a conseq	uence of):	all all	V- 00	1 200			
8/60	icate be executed physician and s the burial-transit	dical	(d			Mor	R. S.	66			
٥	rtifica ng ph as th		IF FEMALE:				19 20-	268	Syl.			
ROX	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ician/Me	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	death 3	Ectopic pregnancy	DE	7		te of delive	ery Day Year
0	the all	ysici	1 ☐ Yes 2 No 9 ☐ Unknown	4□ Pregna 9□ Unknov	nt at time of d wn	eath 5□	Other (specify)	· V		1410		Day . oa.
J.	that the od by detac	by Physic	Part II. Other significant conditions co	ntributing to dea	ath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use contr	ribute to the	ne cause of death?
Hecords,	uires sign ld be	d b	Broken His						1 🗆	Yes 2□No	3 🗆 Prob	ably 4 Unknown
င္ပ	w require been sign	Completed	Broken Hip Broken Arn				-		24a. Wa		Were auto	psy findings available
	The tav te has age 2:	dmo	1-70 (() ///							opsy formed?	prior to co death? 1 □ Yes	impletion of cause of
Vital		a	25. Was case referred to medical					26. Place	1 ☐ Yes of Death (Check only		163	<i>p</i> . No.
	nysici nis ce direc	To B	examiner?	Hospital:	patient 2	ER/Outpatier	it 3□ DOA Oth	er: 4 🗆 Nur:	sing Home 5 Res	sidence 6 Oth	er (Specif	y)
0	ng Pł fter tł ineral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Mont	Injury , Day Year)	28b. Time of Injury	Worl	y at k?		how injury occurr		
<u>S</u>	tendi Jeath. tor: A	cati	Accident investigation 3 Suicide 6 Could not be	8/2/	سی ن			Yes 2 XN		(Street and Numb		
Division of	or All after of Direction by	Certification:	4 ☐ Homicide determined	building	g, etc. (Specify	y)	eet, factory, office		City or 10	own, State)	03 (9	14 Smith Pul
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,		29a. Certifying Phy	sician: To the b	home pest of my kno	wiedge, deat	occurred at the tin	ne, date and	place, and due to the	cause(s) and ma	nner as s	tated.
	n 24 h	edical	(Check only 2 Medical Exami	iner: On the bas and manne	sis of examina	tion and/or in	vestigation, in my o	pinion, death	n occurred at the time	, date and place,	and due to	the cause(s)
	To the within To the comp	¥	29b. Signature and title of certifier				29c. License			29d. Date signed		_
	161-		plulen	4			D-1	7776	•	AUGUST	7 4	12001
	Mag		30. Name and address of person who cobert Verma		of death (Item Seven			erick,	MD 21701			
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 8	32. Re	gis r ar's Signa	ture	Secret :					
	* . * * .	24	AUG U C	2000	Carle Market	1	A STATE OF THE PARTY OF THE PAR					

			1- State of Maryland / Department of He Registrar Amend Item 26 per Dr., G846,08/19/05dhb	ealth and Mo Death	ental Hygie	ene . N2 11 11 5	27231
	0 .		Decedent's Name (First, Middle, Last)		2. Date of Death	000	3. Time of Death
	Physici /Medio		Charles Woodrow Blankenship		Month Saly	Day Year	5 10,401 M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or to	ocation of Death		4c. County of Dea	th
			2004 Barksdale Road Elkton			Cecil	
Ш	Funeral Director		222-40-3400 1 XM 2 F 51 Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) May 14,	rear) C	thplace (State or Foreign ountry) st Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d, Inside City Limits
	Maryl	ō	Delaware New Castle Wilmington				1 TYes 2 No
	1 the	Director	10e. Street and Number 10f. Zip Code		100	J. Citizen of What C	ountry?
	h with	ai D	644 Robinson Lane 19805			United S	tates
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Spec	cify Yes or No-	14. Race - Am Black, Whi	encan Indian,
98	or ite	y Fu	1 1 1 Never Married 2 ☐ Married 1 ☐ Yes 2 1 No	Specify:	noan, etc.)	Specific	
00	72 hours after death with the Maryland naturel; or items 23a or 28e-f show deal Examinate ust be redified at	d by	3 Widowed 4 Divorced Year or Dates:		1	W	hite
21215-0036	in 72	Completed	15. Decedent's Education 16a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)		g 16	6b. Kind of Business	/Industry
212	within liene.	шo	Elementary/Secondary (0-12) College (1-4or 5+) Cook			Restaura	nt.
	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma		
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylar to Health and Mental Hygiene. If item 27 is marked other then "naturel; or items 23a or 28e-f show or other treumetic event, the Madical Examination ust be relified at	5	Charles E. Blankenship	Vida L.	Miller		
lar	2 sho and is my		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street ar			*	
	l and lealth im 27 iher tr		' Marcella Torres/Sister 2004 Barksdale	e Road, E			
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: if item 27 is any injury or other tre once.		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place,	nugus	st 3,	e. Location - City or	
틒	it. P.		'4 □Donation 5 □Other (Specify) Silverbrook Cemete 21. Signature of Funeral Service Licensee 22. Name and Address		W	ilmington	, Delaware
Ba	permit. Departr Importe any inju		Device & Duha Hicks Home 103 W. Stoo	for Fune kton Str	rals, P. eet, Elk	A. ton, Mary	land 21921
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician (Modical	1	Immediate Cause (Final disease or condition resulting in death)				I'm weliste
	/Medical Examiner		Due to (or as a consequence of):				
		e e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				year?
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Sease crifler) that initiated events c.				
0,	be executed ician and burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):				
8760,	ate hys	dicai	d				
9	ertific Jing p	0 1	IF FEMALE:				
Вох	death certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months? 1			23d. Date of de Month	livery Day Year
P.O.	that the death cer ed by the attendin detached for use	by Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 ther (specify) 9 Unknown				
	ires that signed b	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I.	23e. Did toba	cco use contribute t	the cause of death?
Records,	w require: been sig should bi	ed b	Diabetes wellitas COPD		1XYes	2 □ No 3 □ P	robably 4 🗆 Unknown
ဝ၁	law requ as been 2 should	plet			24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
æ		Completed			performe	d? death?	·
Vital	cien: ertific actor,	Be (examiner?	26. Place of Death			
of	di is	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury 2	4 Nursing nom			Sister's Residence
on	ding h. After funer	tion	1 ☑Natural 5 Pending (Month, Day Year) Injury Work?	es 2 \ No	Bd. Describe how	injury occurred	SELVER CHES
Division	Attending it death. sctor: After by the funer	fica	3 Suicide 6 Could not be		Bf. Location (Stre	et and Number or R	ural Route Number,
Ö	el or s afte of Dire	Certification;	4 ☐ Homicide building, etc. (Specify)		City or Town,	State)	
	hour hour unere	cal (29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/or investigation, in my opin	, date and place, ar	nd due to the cau	se(s) and manner a	s stated.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	one) and manner stated.				``
	To To Con	4	29b. Signature and title of certifier 29c. License	number	,	. Date signed (Mont	
	n		1 Javkor, MD 15)14	fr	ighst, 2	005
	9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	MD		,	
	Sta	ite	3 Date filed (Month, Day, Year) 32. Registrar's Signature	, , , ,			
3	Registr		AUG 1 9 2005				

		Please	Type or Print in B			_	•	ole.
		For State Registrar	State of Maryland	_	artment of Healt rtificate of Dea	-	rgiene Reg. 12.00	5 27235
Physici	an	1. Decedent's Name (First, Middle, L				2. Date of D	eath	3. Time of Death
/Medic Examin	al	4a/Facility Name (If not institution, g		· .	4b. City, Toyer, or Locati	Augus on of Death	4c. County	of Death
Examin	ler	Peninsula Region	as Medicas Cen	fer	Salst	ury	Wice	mic
Funeral Director		5. Social Security Number / 6. 222-16-5028	Sex 1 M 2 F 7. Age (In yrs. Ia	ist birthday, Yrs.	If Under 1 Year If Un Months Days Hou	der 24 Hrs. 8. Date of B rs Min. (Month, D	rth ay, Year) 7, 1926	9. Birthplace (State or Foreign Country) DELAWARE
D		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or L	ocation	11411		10d. Inside City Limits
Maryli a-f sho	ctor	DE Sus		IIIFO				1 X Yes 2 □ No
with the	Funeral Director	10e. Street and Number			10f. Zip Code	2	10g. Citizen of W	hat Country?
deeth	nerai	6046 KEHOB	12. Was Decedent Ever in U.S Armed Forces?	6. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes or N	o- 14. Race	- American Indian,
If a rail of the Maryland filed within the Maryland filed within 72 hours after deeth with the Maryland Hygiene. Hygiene, and rail of tems 23a or 28a-f show the than "natural, or tems 23a or 28a-f show it, Ira Madical Erail, at must be notified at	by Fu	1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	1 ZYes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No Spec			White, etc.
72 hou natura		15. Decedent's (Specify only highest g	Education		dent's Usual Occupation kind of work done during r	nost of working	16b. Kind of Bu	
within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	President	•	METAL	FABRICATION
tal Hygi	Be	17. Father's Name (First, Middle, Las			18. M	other's Name (First, Middle		
should be nd Mental marked imatic ev	ို	John Wesler 19a. Informant's Name/Relationship	Allen (Type, Print)	19b. Maili	ng Address (Street and Nu	SADDIE W	Der. City or Town.	State. Zin Code)
and 2 s and 2 s ealth ar m 27 ls		Helen R. All	IEN WIFE	604	le Rehobert	Blus Mils	och, DE	19963
perfution of syndian grants at 12.13.0000 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department if Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other treumstic event, Ira Medical Examinat must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	COI	metery, cre	osition (Name of matory or other place)	Date		City or Town, State
permit. Par Department Importent any injury		*4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		2	SMMULHY CEM. 2. Name and Address of Fa	Hag. 3 2005	Milton	a De
		Kandy	My Nock	- 1	2 5. 2535	r. Denton,		21629
Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on immediate Cause (Final	y one cause on each fine.	. Do not en	er the mode of dying, such	as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque					
	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque		of colon			
be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	0.		c VASCULA	R DISFI	45E_	
be exe	20	resulting in death) cast	Due to (or as a conseque	ence of):				,
indificate ing phy	Medic	IF FEMALE:	0.					
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3[Ectopic pregnancy Other (specify)		23d. Date Mon	of delivery th Day Year
at the d	hysi	1 Yes 2 No 9 Unknown	9□ Unknown					
signed	by	Part II. Other significant conditions	contributing to death but not resul	Iting in the u	nderlying cause given in Pa			bute to the cause of death? 3 Probably 4 Unknown
aw requires I s been signe 2 should be	Completed					24a. Wa		ere autopsy findings available
The la	Com					auto perf 1 □ Yes	ormed? d	rior to completion of cause of eath? □ Yes 2□ No
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 E	R/Outpatie	Othor	ace of Death (Check only Nursing Home 5 Res		r (Snacihi)
ng Phy Mer this	on: T	27. Manner of Death		28b. Time o	f 28c. Injury at Work?	28d. Describe	how injury occurre	
Attending r death.	Certification:	2 Accident investigate 3 Suicide 6 Could not determine	be 28e. Place of Injury - At hon	ne, farm, st	M 1 ☐ Yes 2 reet, factory, office	28f. Location		r or Rural Route Number,
itel or its after ref Dire		4 - Hornidae	building, etc. (Specify)				wn, State)	
e Hosp 24 hou e Fune etely fii	edicai	29a. Certifier 1 Certifying f (Check only 2 Medical Ex-	Physician: To the best of my know eminer: On the basis of examination and manner stated.	rledge, dear on and/or in	h occurred at the time, date vestigation, in my opinion,	and place, and due to the death occurred at the time	cause(s) and mar date and place, a	ner as stated. nd due to the cause(s)
To the within To the complete	Me	29b. Signature and title of certifier	, 01	1110	29c. License numb	er	29d. Date signed	(Month, Day, Year)
		30. Name and address of person wh	o completed cause of death (Item	23a) (Tune	D3459	93	8/2	105
		Nicholas Dabus	n 100 E. Car	10//	St. Salist	vry MD a	21801	
Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	Jre L	Print) St. Salist	/		
DHMH 17 Rev 1/2		7,00 4						
				ORIGIN	AL.			

		,	1 - For State Registrar	State of Maryland /	•	tment of H		, ,	giene	15	27236
			Decedent's Name (First, Middle, Last,					2. Date of Dea	th	ــــــــــــــــــــــــــــــــــــــ	3. Time of Death
	Physici /Medic		Rodolfo	С.	Adr:	iano		Month August	Day 1 2	Year 2005	2150 M
}	Examin		4a. Facility Name (If not institution, give	street and number)			Location of Death		4c. County		
		٠	Anne Arundel Med	lical Center		Annapo			Anne	Arun	nde1
	Funeral		5. Social Security Number 6. Sec	VM 2□E	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(Year)	Coun	lace (State or Foreign try)
	Director		549-74-5737 Usual Residence of Decedent	60	115.			Oct. 24	, 1944	Phil	ippines
	yland		10a. State 10b. County	10c. City, To	wn or Loca	ation				10	Od. Inside City Limits
	Mar-f st	tor	MD Anne An	cundel Anna	apolis	S				ļ	1 ☐ Yes 2x No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of	What Coun	try?
	23a	rai	1702 Treehouse (Court		2	1401		USA		
	er des	Funeral		 Was Decedent Ever in U.S. Armed Forces? 	13. Wa	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, e	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XXYes 2 □ No If Yes, Give Year or Dates:	10	☐ Yes 2【X No	Specify:		Specif	. Asi	an
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show cleal Exaction or usible multist at	ed	15. Decedent's Edu	cation 16	ia. Decede	nt's Usual Occupa	ation		16b. Kind of B	usiness/Ind	lustry
215	within 7; ene. than "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give ki	nd of work done d O NOT use retired;	luring most of work	king			,
21	e filed within at Hygiene. I other than vent, Ire My	Com		• • •	Senio	or Chief			U.S. N	avy	
nd	be filed within 72 hours after death with the Marylan ital Hygiene. sid other than "natural", or flems 23a or 28a-f show other than "natural", or flems 23a or 28a-f show avent, it s Maxical Examiliar at	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			ne)	
Maryland	2 should be and Mental Is marked o	မ	Nazario Adriano					la Samarı			
Mai	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty Ely Adriano (Wii				nd Number or Rui		-		Code)
	1 and 2 Health tem 27 l		20a. Method of Disposition	20b. Place	of Disposit	tion (Name of	Court,		1S, MD 20c. Location -		wn State
Baltimore,	permit. Pages 1 an Department of Heali Important: If Item 2 any injury or other once.		1XXSurial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	lemoval from State cemet	tery, crema	ntory`or other place 7et. Cem.	· 1			•	
altir	nit. F partme ortan injur		21. Signature of Funeral Service Licens		22. 1	Name and Addres	s of Facility	-2005	Crowns	ville	, MD
ä	Depar Impo any ir		> 13- D. Ch		H	lardesty 2 Ridge1	Funeral y Avenue	Home, P.	.A.	D 217	0.1
	1		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the death. Do	o not enter	the mode of dying	, such as cardiac	or respiratory arr	est,	U Z 14	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metasta	7.	Ca					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):	Cance					
	Examine	_	Sequentially list conditions,	Panenal	er	Cance					
	led sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e or):						
	xecul and al-trar	xan	that initiated events resulting in death) Last	Due to (or as a consequence	e of):					-	
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai E		1							
9	tificat ig phy as the										
Вох	eath certifi attending for use as	an/N	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	th 3∏E	ctopic pregnancy			23d. Dat	te of deliver	ry
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ds,	es De pe	by	Part II. Other significant conditions con	imputing to death but not resulting	; in the und	eriying cause give	in in Part I.	239. Dig to		_	e cause of death?
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ior	Attending r death. sctor: After y the fune	atio	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 16al)	Injury	M 1 □ Y	r res 2 □ No				
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	dical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exami	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death o and/or inve	occurred at the time stigation, in my op	e, date and place, inion, death occur	and due to the cared at the time, d	ause(s) and ma ate and place,	inner as sta and due to	ated, the cause(s)
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	a .	, 3	Decedent's Name	(First, Middle, La	s <i>t</i>)	-					2. Date of Dea	th		3. Time of	Death
H	Physici /Medio		Helen			J.		Au	th		August	Day 1 20	Year 05	8:15	D M
	Examir		4a. Facility Name (If r	not institution, giv	e street and numb	er)		4b. City, To	wn, or Loca	tion of Death		4c. County	of Death		
ŧ.,					sted Liv		((Gamb If Under 1	rills	nder 24 Hrs.		Anne			
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Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. ud othar than "natural", or Itams 23c or 28a-f show avant, the Mcdical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4		Armed Force 1 Tes 2 If Yes, Give Year or Date	es? M∑No		was Decedent If Yes, specify			ecify Yes or No- Rican, etc.)		ck, White,	can Indian, etc. hite	
5-0	72 ho natur	eted		5. Decedent's E			16a. Dece	dent's Usual C	ccupation	most of work	ina	16b. Kind of B	usiness/In	ndustry	
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ore,	es 1 a of He of He litem		20a. Method of Dispo		D	20b. P	lace of Dispo	sition (Name matory or othe	of r place)			20c. Location		own, State	
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Baltimore,	pernit. Pages 1 an Department of Heal Important; if item 2 any njury or othar once.		21. Signatury of Fune	J. Serve Cher	isee		22	Name and A Harde 12 Ri			Home, P e, Annap	A. olis. 1	MD 21	401	
	Physician /Medical Examiner		23a. Part1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)	failure. List only	a. Con eac	n line.	uence of):	er the mode o	f dying, suc	h as cardiac o	or respiratory arre	est,		Approximate Interval Bette Onset and I	ween
8760,	ate be executed physician and the burial-translt	Ical Examiner	Sequentially list condif any, leading to immicause. Enter Underly Cause (Disease or in that initiated events resulting in death) Landau (Cause Cause)	jury	· Oct	as a consequal as a con equ		iln	llar	ton	lont			year	s S
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Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e, Place of	Injury - At ho etc. (Specify	me, farm, str			-	28f. Location (Str City or Town	reet and Numb , State)	er or Rura	il Route Numi	ber,
	To tha Hospital or within 24 hours afte Fo tha Funaral Dir. completely filled in I	Medical (29a. Certifier 1 (Check only 2 one)	Certifying Ph	ysician: To the be niner: On the basis and manner	s of examinat	wledge, death ion and/or inv	occurred at ti	ne time, dat my opinion,	e and place, a death occurr	and due to the ca ed at the time, da	use(s) and ma ite and place,	nner as st and due to	ated. the cause(s)	
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			30. Name and address	s of person who	thigh w	death (Item	23a) (Type,	Print)	u Tille	isial	Kay Ga	rcżąlo	8		
	Sta Registr		31. Date filed (Month,		2905 32. Re	strar's Signat	W A	forts							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dean Edward Bette Month

Funeral Director

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

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State

Registrar

AUG 10 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Emily Edith Kendall Bowers 08/06/2005 2:35 pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 23246 Schooner Drive Chestertown Kent 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/25/1934 Birthplace (State or Foreign Country) Days 1 □ M 2 1 → F Hours 220-32-2260 70 Director Yrs. MĎ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event. The Medical Examiner is ust be notified at Director MD Kent 1 ☐ Yes 2 XNo Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23246 Schooner Drive or Items 23a 21620 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No White Specify 3 X Widowed 4 ☐ Divorced 'natural', Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be illed within Department of Health and Mental Hygiene. Important: If item 27 ia marked other than "I any injury or other traumatic event, It a Mex Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Harvey Kendall Carrie M. Dowling 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy B. Jacob/daughter 8590 Caulks Field RD Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Wesley Chapel 08/09/2005 Rock Hall, MD 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral 130 Speer Road Chestertown, MD 21620 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician colon cancer metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Obstructive 1 🗆 Yes 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy perform certificate 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner2 Other: 4 Nursing Home 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural s after dec. 5 Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled in filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0051786 Aug. 8, 2005 MY o. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Fergus 120 Speer Road Chestertown, MD 21620 30. Name and address of person 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 0 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1 Decadent's Name (First, Middle, Last) Month Vear **Physician** 8:30 PM 2005 LARK 08 BRUMBLEY \Diamond /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE NIA MEDICAL CENTER UNIVERSITY OF MURYLAND If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Hours 1**X**M 2□ F 217-74-0112 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b County 10a State 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code permit Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Importent: if item 27 is marked other then "--- any injury or other treumest- any injury or other treumestō Itams 23e 21204 USA 505 Piccadilly Rd. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Elementary/Secondary (0-12) College (1-4or 5+) Electronics Engineer Defense 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Brumbley Barbara Doane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Wife) 505 Piccadilly Rd. Towson, MD Mrs. Jean E. Brumbley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Eldersburg, Maryland Lakeview Mem. Park 8/9/2005 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2.5 yrs RENAL CELL CARCINOMA **Physician** METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Securitiely list and lift in if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): sician Box 68760, Physician/Medical IF FEMALE: usa 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ò in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: d in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 RESIDENT MD AU4176435T15803 WIL 29 SOUTH GREENE STREET, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN TULLY -UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Elden & Spark Registrar

		•	State o		artment of Health and M rtificate of Death		ene 2005	27241
	Physicia		1. Decedent's Name (First, Middle, Last) FECLX BAKER			2. Date of Death Month	Day Year	3. Time of Death
):	/Medic Examin		4a. Facility Name (If not institution, give street and null MASH I VG-TOW ADVENTIST HE	mber)	4b. City, Town, or Location of Death	1,000,0	4c. County of Deal	th Vus Ry
	Funeral Director		5. Social Security Number 6. Sex 117-40-4478 110 M 2 F	7. Age (In yrs. last birthday) 63 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y July 21,	'ear) Co	thplace (State or Foreign buntry) 10
	ryland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	the Ma	Director	Md. Prince Georges	Laure	1 10f. Zip Code	100	. Citizen of What Co	1 ☑ Yes 2 ☐ No
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036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23e or 28e-f show aumatic event, the Medical Examinational Letrodition at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Dovorced 12. Was Dec Armed For 1 Never Married 2 Married 1 Yes, Girls Year or E	^{2□No} 1963-	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
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Mar	d 2 sho th and t7 is m traum		19a. Informant's Name/Relationship (Type, Print) Clint E. Baker – Son		ng Address (Street and Number or Run Nancarles Dr., Ga			
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E			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final	each line.	er the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certificate be executed refault. r death. ector: After this certificate has been signed by the attending physician and better this certificate bases are set to burial transit by the funeral director, page 2 should be detached for use as the burial-transit.	by Physician/Med	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy		23d. Date of de Month	livery Day Year
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Vita Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	A	Other	h (Check only one)		
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	To To the	2	29b. Signature and vite of certifier VL 40	(one)	29c. License number		d. Date signed (Mont	h, Day, Year)
R	1 1 mg		30. Name and address of person who completed cau	se of death (Item 23a) (Type, INCS ROCK VIUS	Print) ROCKVILCE	MO 2085	Z	
**	Sta Regist		31. Date filed (Month, Day, Year) AUG 0 8 2005	Registrar's Signature	de la companya della companya della companya de la companya della	117		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** Bobby August 3, 1:28 A. M Ray Bowens /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, Year) July 29,1937 **Funeral** Birthplace (State or Foreign Country) Days Hours 1**X**M 2□ F Director 237-50-4390 68 Yrs North Carolina Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1X Yes 2 □ No Directo Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 Spring Avenue items 23a 20912 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Noivorced naturai traumatic event, I've Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) U...S. General Services than, Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Administration Painter 2 years other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental C. Jacob Bowens, Sr. 2 Levady **Vivian** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27514 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: if item 27 is any injury or other tra 1711 Curtis Road; Chapel Hill, North Carolina Curtis Bowens (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Aug.7,2005 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery Wilson, North Carolina 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
W. Wesley Chavis III Funeral Services, W. 4 e 1722 North Capitol Street, N.W.; Wash.D.C. 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Pancreatitis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause for injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Atrial Fibrillation Due to (or as a consequence of): physicien Box 68760. Physician/Medical Hypertension the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 20 No certificate 1 🗌 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 9 Funeral C 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO056063 30. Name and address of person of ompleted cause of death (Item 23a) (Type, Print) Kanwaljit K. Nagi, M.D.; 1500 Forest Glen Road; Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 0 8 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Vance A. Biles /Medical July 30 2005 5:04 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number 556-43-7536 If Under 1 Year Months Days 8. Date of Birth Dec 29 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) tXIM 2□ F Hours Min. 29 Yrs. Director CA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f ehow ir then "naturel", or iteme 23s or 28s-f ehov The Medical Examinar must be notified at 10d. Inside City Limits MD Somerset Crisfield Director 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3152 Lawsonia Rd. 21817 U.S. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 ☑ Never Married 2 ☐ Marned 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "nu any injury or other treumatic event, Tra Madik once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Boat Carpenter Construction 8 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Darvin Biles Simone Duquette ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Biles/ Father Darvin 3152 Lawsonia Rd. Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place Macedonia Baptist 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/4/2005 4 ☐ Donation 5 ☐ Other (Specify) Westover, MD Church Cemetery
22. Name and Address of Facility 21. Signature of Funeral Section 11 insee Lewis N. Watson Funeral Home 1618 West Road Salisbury, MD 21801 and from the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart fallure. List only one cause on each line, Approximate Interval Between tmmediate Cause (Final disease or condition resulting in death) Onset and Death Physician HAnging /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as each of the control of the con Examine Due to (or as a consequence of): ettending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Day Year ☐Yes 2☐No detached 9 Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pege 2 should Completed 1 ☐ Yes 2 No 3 Probably 4 □Unknown been certificete has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? 1 X Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 XER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1X Yes 2 No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation after death. 4:10P M 130/05 2 Accident 1 ☐ Yes 2 No 281. Location (Street and Number or Rural Route Number, City or Town, State) 3414 Rivels New Killed 3 Suicide 4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospitel or within 24 hours at To the Funerel D Prise cell WESTWER, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) dles O.C.M.E. July 31, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIPU MID 111 Penn Street, Baltimore, Maryland 21201 JACK M. 31. Date filed (Month, Day, Year) AUG 0 5 2005 32. Redistrar's Signature State Registrar

DHMH 17 Rev 1/2001

P.O.

of Vital Records.

Division

			1- State of Maryland	/ Depa			/lental Hyd		
			Decedent's Name (First, Middle, Last)				2. Date of De		3. Time of Death
	Physici		Marjorie Binghan	n			Month August	Day 200	Year
	/Medic Examin		4a. Facility Name (K. net institution, give street and number)		4b. City. Town, o	r Location of Death		4c. County	
1	⊏xamın	er	114 Bowsprit Court		Gaithers				omery
	Euparal		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year		8. Date of Birt		-
н	Funeral Director		199-03-6546 1□M 2 F 88		Months Days	Hours Min.	8. Date of Birt (Month, Day Feb 20,	y, Year) 1917	9. Birthplace (State or Foreign Country) Pennsylvania
			Usual Residence of Decedent				100 10,	1,71,	r cimby r vanita
	ylan		10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits
	a-f s	cto	Maryland Montgomery Gaith	nersbu	ırg				1 ☐ Yes 2/CXNo
	or 28	ire	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Country?
	23a	Funeral Director	114 Bowsprit Court		20877			USA	
	ems ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. 13. V	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14. Rac	ce - American Indian, ck, White, etc.
90	or It	F	1 Never Married 2 Married 1 Yes 2 No		1□Yes 2XNo		1110011, 010.7		
Ö	y within 72 hours after death with the Maryland jiene. I than insturelt, or liems 23a or 28a-f show The Medical Evariliner must be notified at	d by	3 X Widowed 4 Divorced Year or Dates:					Specif	willte
7	"net	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done	ation du <i>ring most of work</i> d)	ing	16b. Kind of B	usiness/Industry
12	withlir ene. than	m	Elementary/Secondary (0-12) College (1-4or 5+)			7)		C**	. C
2	77 75 7 20		17. Father's Name (First, Middle, Last)	Cashie	ET.	18. Mother's Nam		Grocery	
auc	be tal	Be	James Rooney			Ruth Fra			пе)
Maryland 21215-0036	s 1 and 2 should if Health and Men item 27 is marked other treumatic.	스	19a. Informant's Name/Relationship (Type, Print)	10h Mailin	Address (Street	and Number or Rui			Ch. 7- 0-11
Ma	d 2 sho th and 7 Is my treum		1						
Ġ	1 and Health lem 27 other tr		Barbara McClure/daughter 20a. Method of Disposition 20b. Pla		SOWS TIL	Court Gai	Ltnersbu Date		- City or Town, State
Baltimore,			1 Burial 2 XCremation 3 Removal from State	netery, cren	natory or other place 21 Cremat	ory Augu	ist 5,	200. Coodion	Oity of Town, State
Ē	it. P.		4 □ Donation 5 □ Other (Specify) W • E 21. Signature of Funeral Service Licenses / //			- 1 20			, Maryland
Ba	permit. Page Depirtment of Importent: If any Injury or once.		1 011 11#						• Box 784
-		-							ville, MD 21029
lle			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	DO HOL BILL				rest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	dia	1 In	farct	ION		1 day
	Examiner		Due to (or a a conseque	nce of):	Dica	farct ase			200
		-	Sequentially list conditions, and any, leading to immediate	la C	VISE	use			10 years
	ted nsit	nin	Sequentially list conditions, in any, isodamy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	1105 017.					
	al-tra	Examiner	that initiated events resulting in death) Last Due to (or as a conseque	ince of):					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal E							
687	ficate physics the	edlo	d						
Box (leath certifica attending ph I for use as th	/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnance	cy				22d Da	te of delivery
B	atter I for u	clar	in the past 12 months?		Ectopic pregnancy Other (specify)	•			onth Day Year
P.O.	it the de by the tached	Physician/M	1 ☐ Yes 2 🐼 No 4☐ Pregnant at time of deal 9 ☐ Unknown 9 ☐ Unknown						
	that led b deta		Part II. Other significant conditions contributing to death but not result	ing in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use cont	tribute to the cause of death?
Records,	uires n signa ld be	d by	Alzheimers type demen	Ha			1 🗆 Y	es 2 No	3 ☐ Probably 4 ☐Unknown
00	w require been si should b	Completed					24a. Was	24h	Wasa autana findina available
Re	The lay ate has page 2	mp	Hyperten sion				autop	sy	Were autopsy findings available prior to completion of cause of death?
a		e Cc	25. Was associated to modical				-		1 ☐ Yes 2 ☐ No
Vital	S 80	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 I position 2 Fig.	2/0	oth	26. Place of Deat			
o	Physic this stal di	\vdash		R/Outpatient 8b. Time of	1 3LI DOA	4 Nursing Ho	28d. Describe h	ence 6 Oth	
on	ding F th. After funer	tior	27. Manny of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	Injury	28c. Injun Worl	k? Yes 2 □ No		ow injury occur	
Division	I or Attending after death. Director: After I in by the funer	flca	3 Suicide 6 Could not be 28e. Place of Injury - At hom	e, farm, stre			28f. Location (S	treet and Numb	per or Rural Route Number.
D	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow		
	spite		29a. Certifier 1 Certifying Physicien: To the best of my knowl	edge, death	occurred at the tim	ne, date and place.	and due to the o	ause(s) and ma	anner as stated
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in the Funerel Director of the Funerel Dire	edical	(Check only one) 2 Medicel Exeminer: On the basis of examination and manner stated.	n and/or inv	estigation, in my o	pinion, death occur	red at the time, o	date and place,	and due to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier		29c. License			29d. Date signe	d (Month, Day, Year)
			>/Lell VUA		1400	5433	7	8/4/	2005
			30. Name and address of person who completed cause of death (Item 2	23a) (Type.	Print)			0 1	
			Dr Richard Stefanacci 31. Date filed (Month, Day, Year) AUG 0 5 2005 32. Projector's Signatur AUG 0 5 2005	325	o Starti	ng (ente (t Wooi	DBINE	mb 21797
	Sta		31. Date filed (Month, Day, Year) 32. Figistrar's Signatur	re	/	0			
	Registr	ar	AUG 0 5 2005	JA	rede				

Annapolis

10f. Zip Code

21403

10d. Inside City Limits 1 XYes 2 No

10g. Citizen of What Country?

United States

B.K.S	3	Plea	se Type or	Print in Black Inc	delible lnk. Ensi	ure All Copies	Are Legi	ble.	
KAREN	BALDERSO	N For State		of Maryland / Depa	artment of Health	and Mental Hy	_		
		- State Registrar		Cer	rtificate of Death	7 ,	Rag. No	75 27	21,5
	Physician /Medical	1. Decedent's Name (First, Middle Karen Elizabet)	,	on		2. Date of Dea Month AUG.	Day 1. 2005	Year 095	
		4a. Facility Name (If not institution 670 AMERICANA	-		4b. City, Town, or Location ANNAPOLIS C	of Death	4c. County ANNE	of Death ARUNDEL	
	Funeral Director	5. Social Security Number 217–48–9516	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year If Under Months Days Hours		h y, Year) 6,1947	9. Birthplace (State Country) Mary 1	-

10c. City, Town or Location

Funeral Director

Usual Residence of Decedent

Maryland

10e. Street and Number

10b. County

670 Americana Drive # 56

Anne Arundel

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or Iteme 23s or 28s-1 show eny injury or other traumatic event, its Modical Exp. inter mast be reditional.

Baltimore, Maryland 21215-0036

Physician /Medica Examine

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification:

5 Pending investigation

6 Could not be determined

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)
ALIC 0 2 2005

Division of Vital Records, P.O. Box 68760,

1 2-				1						
/ Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 27 No If Yes, Give	S.	13. Was Decedent of H If Yes, specify Cub			ify Yes or No- ican, etc.)	14. Race - Ar Black, WI	merican Indian, hite, etc. White	
q	3 ☐ Widowed 4 🕅 Divorced	Year or Dates:		12.00	Ороси	·y.		openi, miles		
Completed by	15. Decedent's E (Specify only highest gra	ade completed)	16a.	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry		
E O	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4or 5+)						Newspaper		
Be	3 Secretary Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)									
10 B	Raymond Balderson	Raymond Balderson Marie Meade								
	19a. Informant's Name/Relationship (Marie Balderson /		19b.	Mailing Address (Street 5 East Bay	and Num View	Drive	Route Number, Ann a	City or Town, State	aryland 21403	
ļ	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from State	meter	Disposition (Name of y, crematory or other pla		Da		20c. Location - City		
	4 ☐ Donation 5 ☐ Other (Specif	y) Lak	emo	nt Mem. Gar	dens				lle, Maryland	
	21. Signature of Funeral Service Lice	nsee		22. Name and Addre		ulity J	ohn M.	Taylor Fu	meral Home	
1	Michael Q	Slowy		147 Duke	of G	louces	ter St.	Annapo 1	is, MD 21401	
	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line. a. Athlw Sc/1	Do r	not enter the mode of dyi					Approximate Interval Between Onset and Death	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Ical		d								
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _				23d. Date of d Month	delivery Day Year	
d by Pr	Part II. Other significant conditions of Chronic alcoh	contributing to death but not result	t I.			to the cause of death?				
Complete							24a. Was ar autopsy perform Yes 2	ied? death?	autopsy findings available o completion of cause of ?	
Be (25. Was case referred to medical examiner?				26. Pla	ce of Death	Check only one			
10	1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ E	FVO _U	tpatient 3 DOA	1er: 4 🗌	Nursing Hom	e 5 🗆 Reside	nce 6 Other (Sp	oecify) at scene	

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

gistrar's Signature

28b. Time of Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

cause of death (Item 23a) (Type, Print)
111 PENN STREET, BALTIMORE, MARYLAND 21201

OCME

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

AUG.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2, 2005

28a. Date of Injury (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 12:12 PM 2005 Mae August 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick
If Under 1 Year | If Under 24 Hrs. Frederick Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 X F Months Days Hours 216-22-2049 78 Yrs. Director DEC. 12, 1926 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f show Examiner must be notified at 1 Yes W No Maryland Frederick Frederick Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8017 Fieldstone Drive 21702 United States filed within 72 hours after death the Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: þ 3 Widowed 4 □ Divorced "naturel" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event <u>once</u>. Orivle Stitely Elsie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8017 Fieldstone Dr./ Frederick, Maryland 21702 Cinda J. Spurrier /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/10/2005 | Frederick, Maryland Mount Olivet Cem. ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee Saymond 1621 Opossumtown Pike/ Frederick, MD 23a. Part1. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** a muscardial Infarction 20 minutes /Medical Due to (or as a consequence of): 10 Examiner Dy de Chalestera le Dy de (or as a consequence of): Wars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dementia hemacanomatoxis 1 Yes 3 Probably 4 □Unknown Completed =1p left hi 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an autopsy performed? Yes 22 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of partition 29c. License number 29d. Date signed (Month, Day, Year) D0043389 ro completed cause of death (Item 23a) (Type Print) Momas Ternson Dr Sute 200 Frederick MD21702

State Registrar gistrar's Signature

Brinkley MD

31. Date filed (Month Pag Year 9 ZUUS

Physician

/Medical

. Decedent's Name (First, Middle, Last)

Louise Etter Clifford

Certificate of Death

Do not enter the Dode of Brown such a degiac Stapirate Mirshaels, Md Approkir6a63 Interval Between Onset and Death metastatic to breast well Hears 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUTCHMANS

Reg. No.

8

2005

Talbot

14. Race - American Indian, Black, White, etc.

Specify: White

3:15 PM

9. Birthplace (State or Foreign

Baltimore, MD

10d. Inside City Limits

1 ☐ Yes X No

2. Date of Death

August

3 State Registrar

To the vithin 2 To the

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

CROWLEY

AUG 1.0

MD

CIO

32. Registatr's Signature

Gerald Cochrane

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August Year **Physician** 0138 Gerald Leroy Cochran 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Easton lalbot Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3-27-1918 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 □ F 159-16-9922 Warren, 87 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or items 23e or 28e-f show treumetic event. The Medical Examiner must be notified at St. Michaels Talbot 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21663 24659 Long Haul Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Realtor 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maude Shutt Guy W. Cochran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health at
Importent: If item 27 is
any injury or other treu Nancy C. Strausburg (daughter) P. O. Box 657, St. Michaels, Md. 21663 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 8-9-2005 Dover, De. 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC 21. Signature of Funeral Service Licen b o Box 518 St Mich is that caused the deg h. Do not enter the mode of dying, such as cardiac or respiratory Arrest, St. Michaels, Md. 21663 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) 30 Augus Pnysician andn /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause [Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Hospitel or Attending Physicien: 26. Place of Death Check on one 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 completely filled in by the funeral dir this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; After Injury 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours a To the Funeret L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 125%

9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert B. Sanchez MD 508 Idlewild Ave., Easton, Md. 21601

State 31. D

31. Date filed (Month, Day, Year) 32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0514 AM alter /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospita enter he ster town If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days -09-7462 90 Hours 1 M 2 ☐ F Makyland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location f show 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f shov or other treumstic event, the Medical Examiner miss to notified at MP 1 Yes 2 No **Funeral Director** Queen entreville Annes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street 1 bale LLSA 2161 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other than 'ampiolary or other treumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) s. Militali U.S. ARMY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 homas Ca Bessie Hutchins 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St., Centreville, MD 21617 DIANO 20b. Place of Disposition (Name of cemetery, crematory or other to Date 20c. Location - City or Town, State 8/19/2005 Hurlack 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Pacility Jumie Fart1. Enter the disease, or complete lions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oncet-and Death Immediate Cause (Final disease or condition resulting in death) (ona **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-translt Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physicien Completed by Physician/Medical d as the IF FEMALE use. 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ģ signed Part II. Other ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Yes 2 No 3 Probably 4 Unknown should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 5mans certificate 1 Yes 20 No or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred examiner? 26. Place of Death (Check only one, Hospital: Other: 1 Yes 2 No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Director: After 1 atural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30 Speer

trar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Re

3665

Chestertown

105

			For State Registrar	State of Marylan	d / Depa		lealth and I		iene	27250
¹ ges ÿ P	hysici	an	1. Decedent's Name (First, Middle, Last) SAMUEL A.	CASSITY				2. Date of Death AUGUST	5, 2005ar	3. Time of Death 12:24P. M
	/Medic Examin		4a. Facility Name (If not institution, give s 118 BIG ELK CHAPEL	street and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	
	ineral ector		5. Social Security Number 6. Sex 226-33-3218 Usual Residence of Decedent	7. Age (In yrs. 26	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	9. Birt <i>Ca</i> 1979 RICH	hplace (State or Foreign buntry) HLANDS, VA
. I X I 3-0030 within 72 hours after death with the Maryland ene.	"naturel", or Items 23a or 28a-f show colcal Examinar must be notified at	ctor	10a. State 10b. County MD CECIL	10c. City	y, Town or Lo	cation LKTON				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with th	a or 2	Funeral Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Co	•
death	ns 23	eral	118 BIG ELK CHAPEL 11. Marital Status	ROAD 12. Was Decedent Ever in U.	S. 13.1		.921 lispanic Origin? (Si		JNITED STAT	
72 hours after o	Exeminer	by	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X1 No	an, Mexican, Puert Specify:	o Rican, etc.)	Black, White	
12 D-C	r then "natur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life.	dent's Usual Docup kind of work done o DO NOT use retired	ation during most of wor d)	king	6b. Kind of Business/	Industry
Q & N	로 H		11 17. Father's Name (First, Middle, Last)		MA'	TERIAL HA		ne (First, Middle, M		ORTATION
<u>a</u> <u>a</u>	ked o	То Ве		SSITY			SHARON		GHEE	
Maryic d 2 should th and Mer	I tem 27 is marked r other traumatic e	-	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street			City or Town, State, 2	žip Code)
and 2	n 27 i er tra		SHARON D. MCGHEE/ N			LIMESTON		ILMINGTON	N, DE 19804	4
	= 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	OTTOVAL HOLL STATE		sition (Name of matory or other place			Oc. Location - City or	Town, State
ILIMI iit. Pag artment	7 5		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	MAY		CREMATOR			NEWARK, DE	
parmit. Departm	any l		The Signature of Funcial Service Electrics	+	10	OO N. DIII	PONT PKWY	CER-MULL NEW CAS	IKIN FUNER FLE, DE 19	AL HOMES
/ /Me Exar	sician edical miner	Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and lacking to in recipied cause. Enter Underlying Cause (Disease or injury	Haugin	uence f):					Approximate Interval Between Onset and Death
cate be executed	physicien and the burial-transit	Ical	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
the death certificate	ly the attending phached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
w requires that the	been signed by the should be detached	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
The la	is certiticete has bei director, page 2 sho	Completed						24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of
Physician: 1	irecto	o Be	25. Was case referred to medical examiner? 1 7 es 2 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	Oth		th Check on one		
	⊊ =	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injun Worl	4 Nursing Hi	28d. Describe how	nce 6 D Other (Spec vinighty occurred	My SCENE
Attending r death.	or: After	atlo	1 Natural 5 Pending 2 Accident investigation	FOUND -05	FOUNDS	PM 10	Yes 2 No	Decease	d hanged	d self
To the Hospitel or Attending within 24 hours after death.	to the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office		ELKTOX	J. MD (ral Route Number, ALCHAPEL AL
Hosp 24 hou	stely fil	edical	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my knowner: On the basis of examinat	wledge, death tion and/or inv	occurred at the time restigation, in my of	encin bac etch en	and due to the ear	iso(s) and manner as	stated. to the cause(s)
To the	comple	Mec	29b. Signature and the of certifier	and manner stated.		29c. License	e number	290	d. Date signed (Month	i, Day, Year)
10			30. Name and address of person who cor	mpleted cause of death (Item	23a) (Tyne		.M.E.	AU	GUST 6,200	5
,			S. R. HC	GAN			STREET, BA	ALTIMORE	MARYLAND 2	1201
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Regitrar's Signat	ture	Seed >	,			

			State of Maryland / Department Certificate			•	giene Reg.⊅lo∏ ∏	5 27	251
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Dea	ath Day	Year	Time of Death
200	/Medic Examir	cal	Diane Regina Cain 4a Facility Name (If not institution, give street and number)	4	4b. City, Town, or Lo	Aug 14 ocation of Death	-		5pm
, de			Devlin Manor Nursing Home		Cumberla			Allegany	
h	Funeral Director		220-40-1180 12 1 61 Yrs.	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) Aug 6,	y, Year)	9. Birthplace Country) OH	(State or Foreign
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. lr	nside City Limits
	8a-f st	ctor	MD Allegany Cumberland	d ——				1	∏ Yes 2 □ No
	3a or 2		106. Street end Number 1206 Lafayette Avenue		21502		10g. Citizen of	What Country?	
_	ild be filed within 72 hours efter death with the Maryland lental Hygiene. Ked other than "natural", or items 23s or 28s-f show the other than "natural", or items 23s or 28s-f show the event, the Medical Evarries must be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Decede If Yes, specification of the control of the con	ent of H	dispenic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - American In ck, White, etc.	dian,
002	ral'. o	d by	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Year or Dates:	M No	white				
-212	hin 72 h	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	l Occup k done d e retired	eation during most of work d)	ing	16b. Kind of B	usiness/Industry	′
121	filed wit Hygiene other the	Com	12 2+ cosmetologis	st			salon		
land I	iould be fi Mental H Marked otl	To Be	Russell Ray Jones		18. Mother's Name Linnie Ju			ne)	
Maryland 21215-0020	and 2 shousealth and N m 27 is man her traumat		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (1206 Lafay				or, City or Town, erland	State, Zip Code	
gaitimore,	Pages 1 al ent of Hea nt: If Item :		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name cemetery, crematory or oth Sunset Memorial Pa	her plac		Date 8/18/2005	20c. Location -	City or Town, S	State MD
Salt	permit. It Depertm Importar any injur			Addre	ss of Facility I Funeral Ho	me, PA	Cambo	, idiid	1410
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Ŋ.	Physician		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.					Inter Ons	roximate val Between et and Death
2.	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Glioblas toma N	dul	ti for me	e of	Brain	1	
	ii q	Iner	b. Seizures			,		j i	
-	death certificate be executed e attending physician and ad for use as the buriel-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury cause (Disease or injury cause)	1.1	ce oral	· Lale	10		
58/6U ,	cete be physicia the bui	dicai	resulting in death) Last	tar	ce oran	000			
DOX O	n certifis anding p	_	1 EG tule						
	the atte	Physician/N	Part II. Other significent conditions contributing to death but not resulting in the underlying cau	use giv	en in Part I.	23b. Did to	obacco use co	ntribute to the	cause of death?
ν. Γ	s that the	by Ph				1 🗆 Y	es 2 No	3 Probably	4 🗌 Unknown
Records,	w requires that the de been signed by the should be detached	Completed				24a. Was a	an autopsy med?	available complet	ion of cause
	The law ate has b page 2 s	omo				1□ Y	es X No	of death	1/
	ician: certifica rector,	Be	25. Was case referred to medical examiner?	Othe	26. Place of Death			L	
5	g Phys er this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c	Bc. Injury Work	4 Mursing Ho	me 5 🗆 Resid 28d. Describe h			
JIVISION	Attending Physician: or death. ector: After this certific by the funeral director,	catio	2 Accident investigation NA NA M	1 🗆 '	Yes 2 □ No				
2	tal or At rs efter o al Direct ed in by	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	office		28f. Location (S City or Tow	itreet and Numb n, State)	er or Rural Rou	te Number,
	To the Hospital or Attending Physicien: The law within 24 burus file death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	t the tim	ne, date and place, a pinion, death occurre	and due to the c	ause(s) and ma date and place,	inner as stated. and due to the o	cause(s)
\	Tot Com	Σ	29b. Signature and title of certifier D 29c. 1	License	e number)6242	9	29d Date signed	d (Month, Day,	Year)
1	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AQEEL SALEEM , MD 47 UUra L	h.c	16242 Ane,	Cumber	dand.	MDZ	2502
Ī	Sta		31. Date filed (Month, Day, Year) 32. Registrate Signature	· Lu	1) 000	Jul 1901	/		
П	Registr	All	AUG 2 0 2005 Seems & Species						

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year 2, 1:30 P M 2005 June Catherine Crane August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Ctr. Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 K F Days Hours Yrs 214-28-4903 Director 1-27-1924 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Mudical Exerciper austice nutified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1435 Washington Ave. 21144 USA permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Importent: If tiem 27 te marked other than "netural" new joilury or other traumatic average. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: "netural", or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No White þ Specify: 3 ♥ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 4 years Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Victor Wheatley Ethel Nairn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1435 Washington Ave., Severn, MD 21144 of Disposition (Name of Date 20c. Location - City of Disposition (Name of Date 20c. Location - City of Date 20c. Location Robin J. Acklin/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X1 Cremation 3 ☐ Removal from State Edgewater, MD * 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 8-4-05 21. Signature of Funeral Solvice Acensee 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** our disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit the death certificate be executed the attending physician and P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4□Pregnant at time of death 5 Other (specify) signed by the ther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2□ No 1 Yes 2. No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 110 2 ER/Outpatient 3 DOA 1 Impatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Sign Mula ance nd address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Washington Med. Ctr. Glen Burnie, MD 21061 Darius Cameron, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 4 2005 Registrar

-52	95	1		Ple	ase Type or										e.	
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	સં	,	Registrar 1. Decedent's Nam	e (First, Mid	dle, Last)			runcai	eor	Deali	7	2. Date of D	Reg. N	فك ال	5	27254
_[Physic /Medi		James	Micha	ael D'Aqui	.no						Augus		^{ay} 2005	ear	8:00 P M
	Exami		4a. Facility Name (f not instituti	on, give street and n	umber)					of Death			c. County of	Death	0.00 1
			5. Social Security N		@ High St									Kent		
L	Funeral Director		168-70-3	3053	6. Sex- 1 ☐ M 2 ☐ F	1. Age (in yi	8 Yrs.	Months	r 1 Year Days	Hours	Min.	8. Date of B (Month, D 02/10	irth Pay, Year 1/198	37	Countr PA	ice (State or Foreign y)
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	or 28	Director	10e. Street and Nu					10f. Zip	Code				10g. C	itizen of Wha	it Countr	y?
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Maryland	and and		19a. Informant's Na									ai Route Numb			te, Zip C	code)
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Baltimore,	Pages nent of int: If it iry or o			Cremation	3 Removal from	State	cemetery, crer	natory or o	ther place	9)		Date .		ocation - City		
alt:	permit. Page Depertment of Important: If any injury or once.		21. Signature of Fu				t. Paul		d Addres	s of Faci		3/2005		estert	own,	MD
Ä	Depermine Depermine timbo		> Kic	l V.	Deller	P.		130	ows, Spee:	HeI:	fenbe ad Ch	in & No	ewna own,	m Fune MD 21	ra1 620	Home
			23a. Part1. Enter the shock, or hea.	ne disease, d rt failure. Lis	or complications that at only one cause on	caused the de	ath. Do not ent	er the mod	e of dying	, such a	s cardiac c	or respiratory a	arrest,		A	pproximate
}	Physician /Medical		Immediate Cause (disease or condition resulting in death)		a Dre	whin	4								Ö	nset and Death
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687	leath certificate t ettending physic I for use as the b	Physician/Medical			d										-	
Вох	The law requires that the death certificate are has been signed by the ettending physoage 2 should be detached for use as the	N/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, ou	tcome of pregr								23d. Date of	dolivon	
	ed for	sicia	in the past 12 1 Yes 2	months?		oirth 2 ☐ Fei nant at time of		Ectopic pre Other (spe	egnancy ecify)					Month	Da	ay Year
P.0	res that the de signed by the e be detached f	Phy	9 Unknown													
Records,	uires t signe	-01	r artii. Othor sigiiin	cant conditi	ons contributing to d	eath but not re	sulting in the ur	iderlying ca	ause give	n in Part	I.	23e. Did 1		2 /		cause of death?
COL	w requir s been si should	Completed														ly 4 □Unknown
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Vital	×	Bec	25. Was case referr examiner?	ed to medica	ıl					26. Place	e of Death	1 ☐ Yes (Check only o	2 No	100	6s 2[□ No
of V	ding Physician: h. After this certifica	၉	1 Yes 2□				☐ ER/Outpatien!	3 DO	i -					6 🖾 Other (S	pecify) 8	at scene
ou	ding h	tlon:	27. Manner of Death 1 Natural	5 Pendir		th, Day Year)	28b. Time of Injury		Bc. Injury Work		/ .	8d. Describe				River
Division	Attender deatl	flcat	2 Accident 3 Suicide	investi 6 Could detern	not be	of Injury - At h	D3:30 Y	M factory		es 2 🔽						ROWNED IN
ā	tal or	Certification:	4 🗌 Homicide	GOLOIII			home, farm, stre			D-M.		Bf. Location (: City or To	vn, State)		LEET KENT GO
	Hospi 4 hour Funer ely fill		29a. Certifier (Check only	1 Certifyin	ng Physician: To the Examiner: On the b and man	best of my kn	nwiedne death	Occurred a	at the time	data as						
	To the Hospital or Attending within 24 hours effer death. To the Funerel Director; After completely filled in by the fune.	Medical	one) 29b. Signature and t			ner stated.	and/or my				ui occurre					
	F 3 F 8		110	() - 2 :	1/12 = 0	00	210		O.C.					esigned (Mo ust 6,		
			30. Name and addre	ss of person	who completed caus	e of death (Ite	m 23a) (Type F						Aug	ust 0,	200	, <u>, , , , , , , , , , , , , , , , , , </u>
		27	MMUN	Rim	1.1608	we	11	l Pen	n St	reet	, Bal	timore	, Ma	ryland	212	201
			31 Date filed (Mont)	Day Veerl	20.0	andianda Ci	-4									

- State Registrar MMM M M 31. Date filed (Month, Day, Year) AUG 0 8 2005

			S 1 - For State Registrar	tate of Maryland		rtment o				giene Reg. Nö.	005	27255
			Decedent's Name (First, Middle, Last)						2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia		Jessie Evely	n Durham					August	_	2005	10:22 P M
	/Medic Examin		4a. Facility Name (If not institution, give street	et and number)		4b. City, Tov	wn, or Loc	cation of De	ath	4c. C	ounty of Death	
	Cxamin	er				A	1			Δn	ne Arun	ndo1
-1/			5. Social Security Number 6. Sex	1cal Center 7. Age (In yrs. I	ast birthday)	If Under 1 Y		Under 24 H	s. 8. Date of Bir	th	9. Birtho	place (State or Foreign
	Funeral Director		579-32-8542 ^{1□ M}		Yrs.	Months D	ays F	lours Mi	July 3	1926	Virgi	ntry) nia
Nec	Director		Usual Residence of Decedent									
	land		10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside City Limits
	Many f sh	ō	MD Prince Geor	coe's Snr	ingdal	ρ						1- Yes 2 No
	288-	Director	10e. Street and Number	ge 5 SPI	1118441	10f. Zip Co	ode			10g. Citize	n of What Cou	ntry?
	with a or	<u></u>	9016 Hobart Street			20.	774			U.S	٨	
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Madical Ex. nither most be notified at	by Funeral		Was Decedent Ever in U.	S 13 V			nic Origin?	Specify Yes or No		Race - Ameri	can Indian,
	tram ner	Ë	7 1. Individuo Grando	Armed Forces? 1 ☐ Yes 2 🕱 No	1	f Yes, specify	Cuban, N	Mexican, Pu	(Specify Yes or No arto Rican, etc.)		Black, White,	etc.
36	rs aff	y F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯	No S	Specify:		S	pecify: B1.	ack
21215-0036	hour turns	De la	15. Decedent's Educati		16a Deced	dent's Usual C)ccupatio	n		16b Kind	of Business/In	
<u> </u>	n 72	let	(Specify only highest grade co	mpleted)	(Give	kind of work of DO NOT use i	done durir	ng most of w	rorking			,
7	with:	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	Food Se	rvio	20		Goz	zernmen	t
	Hygin ther		17. Father's Name (First, Middle, Last)			LOOU DO			ame (First, Middle,			
an a	ntai I	Be	Willie	Lee				Rosa	Eubanl	ks		
=	1 Men	2	19a. Informant's Name/Relationship (Type,		10h Mailin	a Address /C	tmot and		Rural Route Number		Tourn State Zin	n Codel
Maryland	2 st and ts n											
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at ance.		Willie Durham/Hus			HODATE		eet Sp	ringdale		tion - City or T	.0774
Baltimore,	of H		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Rem	1 0	emetery, cren	natory or othe	r place)	1				
Ē	Pages ment of I ant: If its ury or o		* 4 ☐Donation 5 ☐ Other (Specify)	Man	cyland	Vetera	ans	8/9	/05	Che1	enham,	Maryland
at at	Depart Import any inj		21. Signature of Funeral Service Licensee	111	22	2. Name and A	Address o	of Facility	J. B. Jen	kins	Funeral	L Home
œ	89 = 9		X N. Hans	fall		7474 L	ando	ver R	oad Lando	ver,M	aryland	20785
и			23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the death cause on each line.	h. Do not ent	er the mode o	of dying, s	such as card	ac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Saptio	5	low	K					Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence	uence of):							
н	Examiner			Col	tis							
	(a)	er	Sequentially list conditions, b. – b. – b. – b. – b. – b. – b. – b.	Due to (or as a conseq	uanou of):	-						
	uted	Ē	cause. Enter Underlying Cause (Disease or injury that initiated events									
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760,	ate be executed sysician and he burial-transit	call	d a									
687	ficate phy is the										1	
×	certifi ding	N.	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregna	incy					23	d. Date of deliv	rery
Box	death certificat e attending phy id for use as th	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregi Other (speci					Month	Day Year
o.	the de	Physiclan/Med	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		(-,,	.,,,					
α.	that teed by		Part II. Other significant conditions contrib	outing to death but not res	ulting in the u	nderlying caus	se given i	in Part I.	23e. Did t	obacco us	contribute to	the cause of death?
S	sign a be	1 by	Constral Va	scular A	ciole	ent			10	Yes 2	r No 3∐Pro	bably 4 Unknown
Vital Records,	The law requires that tte has been signed b page 2 should be deta	Completed	1/11/201/2	1000					04- 346-		Odb Mass sub	and findings available
ec	e law has t	ldu	Aggartens	15W					24a. Was		prior to co death?	opsy findings available empletion of cause of
=		S	Proum	iona					1 ☐ Yes	27 No	1 Yes	2 No
/ita	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?				4-11	6. Place of E	eath (Check only	one)		
of	physic this o	2	1 Yes 2 No		ER/Outpatier		<u> </u>		Home 5 ☐ Resi			ify)
		Ë	27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c	. Injury at Work?		28d. Describe	how injury	occurred	
<u>Ö</u>	Attending r death.	atic	2 Accident investigation			М	1 🗌 Yes	2 □ No	ļ			
Division	of or Attendate death Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	reet, factory, c	office			Street and wn, State)	Number or Rui	al Route Number,
ā	To the Hospital or At within 24 hours after C To the Funeral Direct completely filled in by	Cer										
	e Hospital 24 hours a e Funeral l		29a. Certifier Certifying Physic	ian: To the best of my kno	wledge, deat	h occurred at	the time,	date and pla	ice, and due to the	cause(s) a	nd manner as	stated.
	n 24 he Fi	edical	one)	and manner stated.	mon and on m	vestigation, in	riny opini		.curred at trie time,	uate and p	, and due	To the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. L	license ni	umber		29d. Date	signed (Month	. Day, Year)
		1	Juster 11 Om	all Her	800C	1	43	377	2	8/5	405	
. /	1 5		30. Na re and addre of person who comp	oleded cause of death (Item	n 23a) (Type,	Print)	- (
K	-(X)		HAMC 20	DI MEDIC	AZ V	APKL	UAR	1, A1	UNAPOL	15,2	140/	
1	St	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ature	2000		7		1		
	Regist	rar	AUG 0 8 2005	Mary &	2000	E.						

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Box
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Records,
Vital
of
Division

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		For		State	of Ma	aryland / Depa	artment of I	Health and	Mental Hy	gien	е	
		1 - Stata Registrar				Cei	rtificate of	Death		Rag. Ŋ	2005	27256
Physic	ian	Decedent's Name	ə (First, Middle,	Last)					2. Date of De		ay Year	3. Time of Death
/Medi		Dorothy		В.	I	Dashiell			August	04	2005 ^{Year}	1:20 A M
Exami	ner	4a. Facility Name (I	f not institution, g	give street and nu	umber)		4b. City, Town, o	or Location of Deat	h		c. County of De	ath
		WICOMICO N			-	4	SALISBURY				/ICOMICO	
Funeral Director		5. Social Security N 214-10-7		.Sex 1 ☐ M 2 🔀 F	7. Age	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days		th 1 <i>y, Year</i> 18	(ear) 9. Birthplace (State or Foreig Country)		
		Usual Residence of			07				4/0/19	10	Mai	cyland
rylan how		10a. State	10b. County			10c. City, Town or Lo	cation					10d. Inside City Limits
e Ma	ctol	Maryland	Wicom	LCO		Salisbur	У					1X Yes 2 □ No
eff th	Dire	10e. Street and Nur					10f. Zip Code			10g. C	itizen of What C	country?
aryland 21215-0036 should be tiled within 72 hours atter death with the Maryland and Mental Hyglene. I marked other then "neturel", or Items 23s or 28s-1 show unetic event, it a Medical Engities in its Medical Engities in	Funeral Director	111 Hea	lthway I					804			SA	
er de Items	nne	11. Marital Status		12. Was Dec	orces?		Was Decedent of I f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.))-	 Race - Am Black, Wh 	
36 rs att	by F	1 Never Marri 3 XWidowed		1 □Yes If Yes, G Year or [ive		I□Yes 2∏ No	Specify:			Specify:	white
2 hou			15. Decedent's			16a. Deced	ient's Usual Occup	pation		16b l	Kind of Busines	
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nd se tile al Hy toth	Be (17. Father's Name (18. Mother's Nar		Maide	n Sumame)	
Vla:	2	James E	• Bounds					Annie 1	L. King			
Maryland 21215-0036 at 2 should be tiled within 72 hours at the and Mental Hygiene. 27 Is marked other then "neturel", or treumetic event. The Medical Exert.		19a. Informant's Na						and Number or Ru				Zip Code)
the are		Ann Tay		nter				e Dr., Sa		-		
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item eny injury or other			☐Cremation 3	☐Removal from	State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other pla	ce)	Date	20c. L	ocation - City o	r Town, State
ti. Pa ti. Pa timen timenti		` 4 □Donation	-			Parsons C		8/8		Sa	lisbury,	MD
Balti permit. Departn Importe eny inju		21. Signature of Fu	neral Service Lic	ensee /	d	T C O H	Name and Addre	Funeral F	Home Pro	fess	sional A	Association
_ 13103		22a Barti Fator II	Joll Soll	ouns	200000	FSP 5 the death. Do not enter	UI Snow	HILL Ka.	_Salisb	urv.	MD 218	304
		shock, or hear	it failure. List on	ry one cause on	each iin	θ.			or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	er	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or that initiated events	nditions, mediate	b Due to	(or as a	consequence of):						
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Il Rec The law sate has b	ldu	DCFR	-622101	7					24a. Was autop	SV	24b. Were at	utopsy findings available completion of cause of
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Division To the Hospitel or Attendia within 24 hours after death. To the Funerel Director: A completely tilled in by the tu	sal (29a. Certifier	1 Certifying	hysician: To the	e best o	f my knowledge, death	occurred at the tin	ne, date and place	and due to the	cause(s	and manner as	s stated.
he Ho in 24 he Fu	Medical	(Check only one)	Z Medical Ex	aminer: On the b and man	asis of	examination and/or inv	estigation, in my o	pinion, death occur	rred at the time,	date and	d place, and due	to the cause(s)
To the within 2 To the comple	Σ	29b. Signature and	title of certifier	1			29c. Licens			29d. Da	te signed (Mont	h, Day, Year)
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Z		30. Name and addre				ath (Item 23a) (Type, F					1	
~		MAHESHA THII	MM, MD	14 EASTER	NSH0	RE DRIVE, SAL	ISBURY, MD	21804				
Sta		31. Date filed (Monta	AUG 0 5	2005	i distra	r's Signature	Cart .					
Registr	ar			2000		w is to	MALL!					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Linda Ann Elliott Ju₁y 31 2005 6:06a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death **Examiner** Prince Georges Hospital Cheverly Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**ॉ**F Yrs. 577-68-4690 54 Director March 26,1951 Washington, D.C Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 27 is marked other than "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director D.C. Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 724 21st. Street N.E. 20019 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical permit. Peges 1 and 2 should be file.
Department of Heelin and Mental Hygh.
Important: If liem 27 is marked eny injury or other to one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard Carter Helen Todd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3901 Suitland Rd. Suitland, Md. 20746 Tameka Elliott / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Alexandria, Va. 8-9-05 ` 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan 21. Signature of Funeral Service Life nsee 22 Alexander S. Facily ope Funeral Homes, P.A. Q 0 MO108 5538 Mariboro Pike/Forestville, Md. 20747 rt1. It ter the diserve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARRHYTHMIA Immediate Cause (Final FATAL CARDIAC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physiclen: The law requires that the death certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 🕱 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Medical Certification; To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation efter death 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours e To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of tertifier 057242 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONIFACE 3001 HOSPITHL KEITH 31. Date filed (Month, Day, Year) 82. Registrar's Signature State AUG 0 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. FoAmend Items #1 State of Maryland / Department of Health and Mental Hygiene State Registrar10e & 10f 8/10/05 WCHD/SH Certificate of Deathper Dr&FH 1. Decedent's Name (First, Middle, Last) Margery Eyerly Fleigh 2. Date of Death **Physician** Month Margery Wilcox Fleigh 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Coffman Nursing Home Hagerstown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/07/1916 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Director 123-01-8843 88 Yrs IΑ Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "netural", or Items 23s or 28s-f show traumatic event, the Modical Examinating that by notified at MD Director Washington Hagerstown 1X Yes 2 □ No 10e. Street and Number 1321 Oak Hill Avenue 21742 10f. Zip Code 10g. Citizen of What Country? 1321 Oakhill Avenue US Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ould be filed within 72 hours after Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No White Spacify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Kendall Eyerly Margaret Sophia Wilcox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Nancy F. Daugherty/Daughter 1748 Founders Hill S., Williamsburg, VA 23185 f Health item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Important: If it eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 08/09/2005 Smithsburg, MD 21. Signature of Funeral Service Licensia 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Jach line. Approximate nterval Between Immediate Cause (Final disease or condition resulting in death) Prysician wown /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Game Known to Physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐NO 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 atural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deatl Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature, and title of certifier 30. Name and address of East use of death (Item 23a) (Type, Print)

10H-20

State Registrar

				State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 115	27250
		Physic /Medi		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	3. Time of Death
		Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ST AGNES HOSPITAL 4c. County of Death BALTIMORE	17073
		Funeral Director		5. Social Security Number 1 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birth (Month, Day, Year) 48 Aug UST 9 2005 M	place (State or Foreign intry)
		Maryland	tor		10d. Inside City Limits 1 Yes 2 □ No
		ith with the 23a or 28 ust be not	al Director		ntry?
	920	be filed within 72 hours after death with the Maryland ntal Hygiene. Id other then "natural", or Items 23a or 28e-1 show event, the M. of all Ex. "ither "ust be notified at	by Funeral	3 Wildowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Specify:	
A.	21215-0036	within 72 hou ane. Ihan "natura	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) A) A 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INFANT	
J/	Maryland 2		To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame)	
4 30	re, Mar)	1 and Health Iem 27	ľ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip. NEELO FAR MOTHER 403 WARREN TREE WAY BALTO 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town)	MD ZIZZ9
220	Baltimo	permit Pages Depar ment of I Importent: If it any injury or o		Surial 2 Cremation 3 Removal from State Commetent, crematory or other place) OCTOBER BALTIMOR	AL
2		<u>7</u> ∪ = 9		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
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	,8760,	Attending Physicien: The law requires that the death certificate be executed in death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the buriat-transit.	dical Examiner	d	, , , , , , , , , , , , , , , , , , , ,
	P.O. Box 6	that the death certific ed by the attending p detached for use as	Completed by Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 mg/mfs? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Month Month 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month ery Day Year	
		w requires that been signed t should be det	ed by P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the CATREME PRIMATURITY 1 Yes 2 No 3 Prob	he cause of death?
	al Recc	i cien: The law recertificate has be			psy findings available mpletion of cause of
	Division of Vital Records,	tending Physicien: leath. tor: After this certific the funeral director,	on: To Be	Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify	γ)
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)	With To I	Z	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, I) Di4955 August 10,	2005
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARTURO B. SANTOS MD 900 ATON AVE BALTIMORE, M 31. Date filled (Month, Day, Year) 32. Registrar's Signature	MARYLAND
		Sta Registr	15		21229

Physician / Medical Examiner 1. Decedent's Name (First, Middle, Last) Margarete Mae Fidler 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d. Carroll Funeral Director Funeral Director 10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 2. Date of Death Month Day Year 8:00 A Margarete Mae Fidler 4c. County of Death 4c. County of Death 4c. County of Death Carroll 1d. Month, Day, Year Months Days Hours Min. Days Min. Days Hours Min. Days Min. Days Min. Days Min. Days Min. Days Min. Days				For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment of			rgiene Reg. Np. 1 1 5	27260
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Description of Part Annual State (Co. Control) 102. Poly Town or Location 102. City Town or Locati		Funeral								rth ay, Year) 9. E	Birthplace (State or Foreign Country)
To company the property of the		Director			1	93 Yrs.					
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Description of the property of the part of the property of the part of the par		death ms 2	nera		12. Was Deceden	t Ever in U.S. 13.		Hispanic Ori	gin? (Specify Yes or No	0- 14. Race - Ai	
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23. Part I: Enter tot disease, or complications that caused the destr. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Printing in death) 25. Part I: Enter tot disease, or complications that caused the destr. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Printing in death) 25. Securitally list conditions, if any, leading to an immediate Cause (Printing in death) 25. Was according in the conditions, if any, leading to an immediate Cause (Printing in death) 26. Was according in the conditions, if any, leading to an immediate Cause (Printing in death) 26. Was according in the conditions, if any, leading to an immediate Cause (Printing in death) 26. Was according in the conditions and interest the mode of dying, such as cardiac or respiratory arrest. 27. Due to (or as a consequence of): 28. Due to (or as a consequence of): 29. Unit to (or as a consequence of): 29. Unit to (or as a consequence of): 20. Unit to (or as a consequence of): 21. Unit to (or as a consequence of): 22. If yes, outcome of pregnancy 23. Unit to (Printing in death) 24. Was an in the conditions of the cause of death? 25. Was according to the cause (Printing in the underlying cause given in Part I. 26. Due to (or as a consequence of): 27. Unit to (or as a consequence of): 28. Place of Death (Printing an acable) 29. Was according to the cause of death? 29. Was according	Je,	s 1 a of Hei itam otha		20a. Method of Disposition		20b. Place of Disp	osition (Name of				or Town, State
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Physician (Medical Examiner Medical Examiner M	<u> </u>	89 = 89	110	17.1.	CC	0354	269 Frede	rick St	reet, Hanover	, PA 17331	
Trivision Medical Examinor Medical Medic				23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that cause y one cause on each	ed the death. Do not en line.	ter the mode of dy	ring, such as	cardiac or respiratory a	rrest,	Interval Between
Due to (or as a consequence off): Constitution	TE .	Priysician	10	disease or condition	. A	SEVI)					Onset and Death
Sequentially list conditions: Sequentially list conditions:				resulting in death)	Due to (or a	s a consequenc					
That initiated events a consequence of): Consider the construction of the construct		Lxammer		Sequentially list conditions,	b. Due to for a						
That initiated events a consequence of): Consider the construction of the construct		bed isit	를	cause. Enter Underlying	Due to (or a	s a consequence or):					
Part		xecul and al-trar	xan	that initiated events		s a consequence of):					
25. Was case referred to medical systems of peath (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 1	09/	siciar buris	ä		d						
25. Was case referred to medical systems of peath (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 1	687	ificate g phy as the			G.						
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25. Was case referred to medical systems of peath (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 1		death	icia		4 ☐ Pregnant :			cy		Month	Day Year
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25. Was case referred to medical systems of peath (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 1	ec	law las be	ople.						autor	psy prior to	o completion of cause of
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 28b. Time of Injury 3 Suicide 4 Homicide 28a. Date of Injury 3 Suicide 4 Homicide 28b. Place of Injury 4 Month, Day Year) 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Describe how injury occurred 28d. Describe how injury oc	H		Co							ormed? death'	?
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The proof of the p	of	문 유 등	 		1 _ Inpat		nt 3 DOA	4 LI Nui			pecify)
29a. Certifier (check only one) 29a. Certifier (check only one) 29b. Signature and title of general and manner stated. 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Her best P-Hern Lorson S-MD 2473 Man Lorson R Manner Manner Manner Stated. 31. Date filled (Month, Day, Year) 32. Registrate Signature		Jing After fune	tion	1 Natural 5 Pending		ay Year) Injury	W	ork?		now injury occurred	
29a. Certifier (check only one) 29a. Certifier (check only one) 29b. Signature and title of general and manner stated. 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Her best P-Hern Lorson S-MD 2473 Man Lorson R Manner Manner Manner Stated. 31. Date filled (Month, Day, Year) 32. Registrate Signature	İSİ	Attan deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not	be 390 Blace of Ir	niury - At home, farm, st				Street and Number or	Rural Route Number.
29a. Certifier (check only one) 29a. Certifier (check only one) 29b. Signature and title of general and manner stated. 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Her best P-Hern Lorson S-MD 2473 Man Lorson R Manner Manner Manner Stated. 31. Date filled (Month, Day, Year) 32. Registrate Signature	<u>S</u>	al or after	erti	4 Homicide	building, e	atc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or To	wn, State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Her pet P. (Hunderson J. MP 2473 Manchoffer RI Manchoster MD 21102) 31. Date filed (Month Day Year) 32. Registrate Signature		ospita hours unara ly fille		29a. Certifier 1 Certifying F	hysician: To the bes	t of my knowledge, deat	h occurred at the t	time, date and	d place, and due to the	cause(s) and manner	as stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Her pet P. (Hunderson J. MP 2473 Manchoffer RI Manchoster MD 21102) 31. Date filed (Month Day Year) 32. Registrate Signature		the Hi in 24 the Fi	edic		and manner s	of examination and/or instated.	ivestigation, in my	opinion, deat	th occurred at the time,	date and place, and d	ue to the cause(s)
31 Date tiled (Monto Day Year) 32 Begittrar's Signature			Σ	29b. Signature and title of genifier	206						
31 Date tiled (Monto Day Year) 32 Begittrar's Signature		WIL		My Vi	1 - 1		Po	2051	924	August 4.	2005
31 Date tiled (Monto Day Year) 32 Begittrar's Signature		1 J		16 / 40 (6 0		death (Item 23a) (Type,	Print)	. 1	2 / 111 6	/ 1/1/	>./~
Registrar AUG 0.5 2005		-0.		The profession of the professi	32 Books	trar's Signature		7491	V Manch	pstq-1111	alla
AND AND AND AND AND AND AND AND AND AND	*3) %-				2005	que, K	Law.				

05	5256		Please Type or Print in Black Indelible Ink. Ensure All		_	
			State of Maryland / Department of Health and Me 1 - State Registrar Certificate of Death		giene Reg. No. 2 () () 5	27261
5	* * * * * * * * * * * * * * * * * * *		1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
	Physici /Medic			August	04 2005	12:12 P M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	
			28194 Rockawalkin Ridge Road Hebron 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Wicomic	
3	Funeral Director		218-34-3341 Usual Residence of Decedent	Feb. 6,	1938 Mar	nplace (State or Foreign untry) yland
	/land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-f et	ctor	Maryland Wicomico Salisbury			1 ☐ Yes 2 X No
	or 28	Directo	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
	e 23a				USA	
	fer de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 2 Never M	ify Yes or No- lican, etc.)	14. Race - Ame Black, White	
50	urs af	þ	3 Widowed 4 Divorced If Yes, Give 1955-1977 1 Yes 2 No Specify:		Specify: Bla	ck
ئ 1	be filed within 72 hours after death with the Maryland lat Hyglene. d other than "natural", or Items 23a or 28s-f show event, the Madical Exeminer must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	a	16b. Kind of Business/	ndustry
21215-0036	within ane. then "	mpi	Elementary/Secondary (0-12) Colfege (1-4or 5+)	, I	United State	es Air Force
	Hygie Hygie other	e Co	Tech Sgt (retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle,	Maiden Surname)	
<u>a</u>	ihould be id Mental marked o matic ev	To Be			Smith	
Maryland	should have	, V	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural		r, City or Town, State, Z	
	s 1 and 3 if Health Item 27 other tri		Clarie Fortt/spouse 28194 Rockawalkin Ridge			
Baltimore,	9 = 5		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	ite	20c. Location - City or	Town, State
	urtmen urtmen ortant: njury		4 Donation 5 Other (Specify) MD V.A. Cemetery 0812/2 21. Signature of Funeral Service Licenses	2005	Hurlock, Ma	ryland
n	permit. Departri Imports any inju		1213	Jersey	Road, Salisi	oury, MD 21801
		1	23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	HAPEL respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition assured to a condition of earth) a. Attention of earth assured to a condition of earth and a condition of earth assured to a condition of earth a		4.	Onset and Death
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	CXAMILIE	_	Sequentially list conditions, b			
	uted I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c			
,	be executed sician and burial-transit	Еха	that initiated events c. The sullting in death) Last Due to (or as a consequence of):			
2/60	ate be nysicia he bu	cai				
200	certificate Iding phys	Med	IF FEMALE:			
X O D	atter for u	cian/Medic	23b. Was decedent pregnant in the past 12 months? 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delin	very Day Year
j.	y the	Physic	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown			,
7	requires that een signed b nould be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
ordi.	w require been sig should b			1 🗆 Ye	es 2 No 3 Pro	bably Unknown
ecor	2 St	ompleted		24a. Was a autops		opsy findings available ompletion of cause of
Ĭ R	Thate ate	Con		perform perform	med? dati? 2□No 1 es	2 No
VIII	Physician: Th this certificate ral director, pag	Be	examiner? 20. Place of Death		77	
ō	ding Phys h. After this funeral di	٦.	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home		ence 6 Other (Spec.	hyat scene
VISION	Attending ir death. ector: After by the funer	atior	28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending (Month, Day Year) 28 No Injury 4 No Injury 5 No Injury 8 No Injury 9 No Injury 1 No Injury 9 No Injury 1 No I		and any accounts	
<u> </u>	after death after death Director: #	ertification:	3 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (St City or Town	treet and Number or Rui	al Route Number,
2	oitel or urs afte ral Dir iled in	O	0			
	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and and manner stated. 20a. Certifier (Check only one) 20a. Certifier (Check only one)	d due to the ca at the time, da	ause(s) and manner as late and place, and due	stated. to the cause(s)
	vithin To th compl	Me	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Month,	Day, Year)
)	200		tatu Uronica-tollaro O.C.M.E.		August 05,	2005
9	1, 3		30. Name and address of person who completed cause of Lath (fem 23a) (Type, Print)			
3 5	X		31. Date filed (Month, Day, Year) 32. Resistrar's Signature	iore, Ma	aryland 212	ΩŢ
	Sta Registr		0.000			
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			For Stete Registrer	State	of Maryla	ind / Dep <i>Ce</i>		nt of Hea te of De		lental Hy	giene Reg. MG.	000	27262
Př	nysicia	an	1. Decedent's Name (First, Midd		TT OOD					2. Date of D	eath Day	Year	3. Time of Death
	Medic xamin		RUSSEI 4a. Facility Name (If not institution		FLOOD umber)		4b. City	, Town, or Loca	ation of Death	AUG		2005 County of Dea	11:12
	, annin		NATIONAL NA	VAL MEDIC	AL CEN	TER		BETHE	SDA			MONTGO	MERY
	neral ector		5. Social Security Number 006-54-8505	6. Sex 1⊠M 2□F	7. Age (In yr	s. last birthday, 55 Yrs.	If Unde Months		Under 24 Hrs. ours Min.	8. Date of B (Month, D February		C	thplace (State or Foreign buntry) ada
and	72		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or L	ocation						10d. Inside City Limits
Mary	fieds	tor	Maryland St. Ma	rv's	L	exington	Park						1 ☐ Yes 2 📉 No
ith the	E D.S.	Director	10e. Street and Number					p Code			10g. Citi	zen of What Co	ountry?
ath w	Tank	ral	46619 Midway Driv		-1	110	144 - 5	20653			US		and the second second
I all y later to the Maryland 2 should be filed with the Maryland and Mannahal Ayylane. Is marked other than "natural" or liems 23a or 28a-f ahow	tremained creekt, the Madical Examiner must be mailing at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Ma	ried Armed F	2 □ No ive		If Yes, sp	edent of Hispar ecify Cuban, M 2 🔯 No Sp	nic Origin? (Sp lexican, Puerto pecify:	ecity Yes of N Rican, etc.)		14. Race - Ame Black, Whit Specify: Whi	te, etc.
hours	A Ex		3 Widowed 4 Divorce	Year or l	Dates:	16a Dece	dent's Us	al Occupation				nd of Business	
Hin 72	Micdig	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	(Give	kind of w	ork done during use retired)	g most of work	ring	100.14	70 07 00311033	modify
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should Me	metic	L _O	Russell Clifton I 19a. Informant's Name/Relation	r Town, State,	Zip Code)								
2 ± 5 € 7	: =		Ellen R. Flood / W	and 2065	3								
ages 1 and 1 de la la la la la la la la la la la la la	or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	cation - City or	Town, State								
permit. Pages 1 Department of H	eny injury once.		* 4 □ Donation 5 □ Other (21. Signature of Funeral Service		0.	Clington Ceme	2. Name a	nd Address of	Facility	2005		gton, Vi	rginia
a & & §	2 G		Michael	KAp	rdin	P.	.O. Bo	ley-Gardi x 270, Le	eonardtov	vn, Mary	Land 20	0650	
			23a. Part1 Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the de each line.	eath. Do not en	ter the mo	de of dying, su	ich as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Physi /Med	ician dical		Immediate Cause (Final disease or condition resulting in death)		TASTAT	IC SUPR	AGLO	TIC SQ	UAMOUS	CELL C	ANCEF	<u> </u>	
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ted	nsit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a cons	equence of):							
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cate be	the br	dlcal		d									
certifi	use as		IF FEMALE: 23b. Was decedent pregnant		utcome of preg						2	23d. Date of de	livery
The law requires that the death certification has been stored by the attendance	should be detachad for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 □ Fe Inant at time of nown		□Ectopic □ Other (s					Month	Day Year
es that	pe deta	by Pł	Part II. Other significant condit	ons contributing to	death but not r	esulting in the u	underlying	cause given in	Part I.	23e. Did	tobacco u		the cause of death?
require	hould											No 3□Pi	robably 4 Unknown
The law	90 2	Completed								24a. Wa auto peri 1 ☐ Yes	s a <i>n</i> opsy formed? 2 □ No	prior to death?	utopsy findings available comptetion of cause of
VILGIEN: The contributed	ector,	Be	25. Was case referred to medical examiner?						Place of Deat	h (Check only	оле)		
Physical Phy	ral dir	1: To	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	☐ ER/Outpatie				ome 5 Res		Other (Spe	cify)
ath.	e fune	atlor	27. Manner of Death 1 XNatural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No										
l or Atte	d in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	nined 289. Plac	e of Injury - At ding, etc. (Spe	home, farm, st	reet, facto	ry, office			(Street and own, State)		ural Route Number,
To the Hospital or Attending Physicien: within 24 hours after death.	completely filled in by the funeral director.	edical C	29a. Certifier 1 Netrifyi (Check only one) 2 Medice	g Physician: To the Exeminer: On the and ma	e best of my k basis of exami	nowledge, dea nation and/or in	th occurre	d at the time, da n, in my opinion	ate and place, n, death occur	and due to the red at the time	e cause(s) , date and	and manner as place, and due	s stated. a to the cause(s)
To the	comp	Me	29b. Signature and title of certific				2	c. License nur	mber			e signed (Mont	_
34	-		1/9		×.	mp		010574	63A (IN	1)	(0 - 89	9-205
II				who completed cau		em 23a) (Type	, Print)		AL NAVA			CENTER	
	Sta	te	AARON HOLLEY 31. Date filed (Month, Day, Year	32.	IC USA Regi ra ar's Sig	nature			DA MD 2	20889-5	600		
R	egistr		AUG		A Second	J. H.	Also.	R.O.					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2005 4:45 Rita A. Ford July 28, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Heritage Harbour Health Center Annapolis If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. | Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🗓 F Yrs Director 87 MARCH 02,1918 KENTUCKY 402 30 0010 Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or Items 23a or 28a-f ehow other traumatic event, the Medical Exercit et insist be modified at 1 ☐ Yes 2 ☐ No Director MARYLAND ANNE ARUNDEL **EDGEWATER** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death in and Mental Hygiene.
Is marked other then "naturel", or Items 23s. 316 CADLE AVENUE 21037 Completed by Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: WHITE 1 ☐ Yes XXNo Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COSMETOLOGY BEAUTICIAN 8 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LAURA SHEPHERD ALEX ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s. ment of Health an JOYCE J. LENTINI/ DAUGHTER 316 CADLE AVENUE, EDGEWATER, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 XRemoval from State ö permit. Page Department of Important: If any injury or once. 8-2-05 WHITE POST CEMETERY ^ 4 □ Donation 5 □ Other (Specify) MEDARYVILLE, IN. 22. Name and Address of Facility George P. Kalas Funeral Home of Funeral Service Licenses allen 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory exest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final 0 Approximate Interval Between Onset and Death Priysician Closed head injury due to fall disease or condition resulting in death) 3 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit be executed Due to (or as a consequence of) the attending physician hed for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ History of cardiovascular disease 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 2**∑** No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury e Hospital or Attending Pl 24 hours after death. e Funerel Director: After ti 28d. Describe how injury occurred Certification; Natural 5 Pending 7:00 investigation 7-20-05 2X Accident Patient fell 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel C Heritage Harbour Health Center Annapolis, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9055 Chevrolet Dr., Ste. 100, Ellicott City, MD 21042 Njideka Udochi, M.D.31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001 AUG 0 3 2005

	1- State of Maryla	nd / Department of Health and I Certificate of Death	Mental Hygiene
Physician	1. Decedent's Name (First, Middle, Last) Robert Louis GRUBB		2. Date of Death Month Day Year GUCLIST 9 2005 3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Death Hagerstown	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs 220−18−0463 1 ☑ M 2 ☐ F 79 Usual Residence of Decedent	s. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 9,1925 9. Birthplace (State or Foreign Country) Virginia
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, I'm Medical Examination and beneating ance. To Be Completed by Funeral Director	10a. State 10b. County 10c. C	Hagerstown 10f. Zip Code 21740 U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA Decify Yes or No- 14. Race - American Indian,
5-0036 2 hours after satural', or ite ical Examples	3 ☑ Widowed 4 □ Divorced	1 ☐ Yes 2 ☒ No Specify:	Specify: white
altimore, Maryland 21215-0036 rmit. Pages 1 and 2 should be filed within 72 hours at partment of Health and Mental Hygiene. Protent: If item 27 is marked other trans "natural", or protant: If item 27 is marked other transfer Example. Ca.		(Give kind of work done during most of wor life. DO NOT use retired) maintenance supervise 18. Mother's Nar	_
aryland should be fil and Menial H smarked out umatic even		Mary Go	olda Myers ral Route Number, City or Town, State, Zip Code)
e, Ma 1 and 2 s Health an em 27 is i	Susan Alsip - daughter		Hagerstown, Maryland 21740 Date 20c. Location - City or Town, State
Pages ment of the ant: If ite	1X Burial 2 Cremation 3 Demoval from State	edar Lawn Mem. Park 8/1	2/05 Hagerstown, Maryland
Balti permit. Departr Importa any inju	21. Signature of Foreral Service Licensee		INNICH FUNERAL HOME ., Hagerstown, Md. 21740
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the decisions, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse	myocardial justa	yor respiratory arrest, Approximate Interval Between Ossey and Death
58760, licate be executed physician and s the burial-transit edical Examiner			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director; page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medi		tal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
rds, P quires that n signed b uid be deta	WANES III III	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 10 3 Probably 4 Unknown
Vital Record itcian: The law requir certificate has been si rector, page 2 should			24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ NO
vaician s certificator director.	Hospital:	Othor	th (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify)
Division of Vital Retail or Attending Physician: The statler death. at Director: Atter this certificate he do in by the funeral director, page		28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred
Division To the Hospital or Attention within 24 hours after dealt To the Funeral Director: completely filled in by the		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
he Hospi in 24 hou the Funer pletely fill	29a. Certifier 1 Certifying Physician: To the best of my kr (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)	
To us within To us comp	29b. Signal February Signal Control of Contr	29c. License number	29d. Date signed (Month, Day, Year) AUGUST 10, 2005
3H-10+1	30. Name and address of person who completed cause of death (te 324 East Antiethm (Tall).	om 23a) (Type, Print) FUITE 200 HAGRESTAN	M MD 31740
State Registrar	31. Date filed (Month Dig Your) 2005	B. Soule	

filed within 7 I Hyglene. 2 should ba f and Mental H permit. Pages 1
Department of H
Important: If ita
any injury or ott

Physician /Medical Examiner

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23a

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"natural"

Is markad other than

itam 27

other traumatic event, the Medical Examinar must be notified at

Examine attending physician and for use as the burial-transit Physician/Medical the À signed b þ page 2 should Completed funeral director Be death.

death cartificate be executed P.O. Box 68760 Division of Vital Records, Hospitel or Attending Physician: after deatl Director; within 2 To the

Month CAROLE IRMA GEIST 4ugust 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Easton Talbot Memorial Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months Days Hours Min 1 ☐ M 2 🗶 F 192-26-0092 Yrs. 70 9-29-1934 PENNSYLVANIA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location MD TALBOT TRAPPE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3906 MAIN STREET 21673 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 **K** No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) **ELECTRONICS** Elementary/Secondary (0-12) College (1-4or 5+) ASSEMBLY WORKER MANUFACTURER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HAROLD DETRICK EDNA EITEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROY C. GEIST/SON HUSBAND P.O. BOX 124, TRAPPE, MD 21673 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTER, LLC 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 8-10-2005 STEVENSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. NHOF MERCERON 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. million trun ludone him Myed Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 W No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

Day

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 hpatient

24a. Was an autopsy performed? res 2 2 No 1 Yes

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

10d. Inside City Limits

¥ Yes 2 □ No

Approximate
Interval Between
Onset and Death
// MonthS

Year

26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

23e. Did tobacco use contribute to the cause of death?

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 🗋 Suicide 4 | Homicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

2 ER/Outpatient 3 DOA

28b. Time of

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signator and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID SMITH, M.D., 29466 PINTAIL DRIVE, EASTON, MD 21601

31. Date filed (Month, Day Year 100 2005 State Registrar

25. Was case referred to medical

2 No

examiner?

1 🗌 Yes

29a. Certifier

(Check only one)

27. Manner of Death



				1 - State Amend It	State em 29d p	of Maryl er Dr.	and / Dep ,G847	artment of h	Health and N	lental Hygie	ene GRAAAS	27266
		~		1. Decedent's Name (First, Middle						2. Date of Death	£000	3. Time of Death
		ysicia Aedica		Abbie Lorra	ine Gatt	on				AUGUST	08 20	
		amine		4a. Facility Name (If not institution				4b. City, Town, o	or Location of Death		4c. County of D	e <i>a</i> th
			а	St. Mary's Hos	pital				rdtown		St. Mar	
	Fun	_		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	- , ,	yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9.1	Birthplace (State or Foreign Country)
	Dire	ctor		218-22-8509 Usual Residence of Decedent	1 2 3 1		81 Yrs.			February 19	9, 1924 M	aryland
	land	74		10a. State 10b. County		10c.	. City, Town or L	ocation				10d. Inside City Limits
	Mary -1 sh	lied	ģ	Maryland St. Ma	c37		Hollywoo	d				1 ☐ Yes 2 🔯 No
	death with the Maryland ms 23a or 28e-f show	E .	Director	10e. Street and Number	уѕ		norrywoo	10f. Zip Code	-	10g	Citizen of What	Country?
	h with	SI Es		25294 Vista Road				20636			USA	
	deat	T.	Funeral	11. Marital Status	12. Was De	ecedent Ever i Forces?	in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		merican Indian,
	after or lite	E		1 Never Married 2 Marr		s 2 🔀 No		1 ☐ Yes 2 ☒ No		Triodit, oto.,	Specify:	Title, etc.
	DOG nours	EXB	d by	3 ♥ Widowed 4 □ Divorced	Year or	Dates:					W	nite
	15-1	adica	Be Completed	15. Decedent (Specify only highes	's Education t grade complete	d)	16a. Dece	edent's Usual Occup Brind of work done OO NOT use retire	pation during most of work id)	ing 16	b. Kind of Busine	ss/Industry
	withir and than	M S	щ	Elementary/Secondary (0-12)	College	(1-4or 5+)		omemaker	ia)		Own Home	
	Hygin A	ant, I	ပိ	17. Father's Name (First, Middle,	Last)	****	1 11	Olifelliake1	18. Mother's Nam	e (First, Middle, Ma		
	d ba	C 8V6	To B	William Douglas Mo	rgan				Ida Russe	11		
5	Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 27 Is marked other than "neturel", or	ımati	-	19a. Informant's Name/Relations			19b. Mail	ing Address (Street	and Number or Rur		City or Town, State	e, Zip Code)
20	Mg 2 nd 2 lith a 27 ls	rtrai		Frances Gatton / I	aughter		25294	Vista Road	, Hollywood	. Marvland	20636	
2	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should ba filed within 72 hours after death with the Marylan Department of Health and Mental Hygienethin (Propertment of Health and Mental Hygienethin (Propertment: If item 27 is marked other than "neturel", or Items 23a or 28e-1 show	othe		20a. Method of Disposition		20		osition (Name of amatory or other pla		Date 20	c. Location - City	or Town, State
3	Page Hent c	ry or		1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (S)	Maryland							
\leq	alti mit. partir	luin a		21. Signature of Funeral Service	icendee	/	1 2	1 Cemetery 2. Name and Addre	ess of Facility			
0	m 185	8 8		michael 16	ern Ho	reder	P	.u. box 270	ardiner Fund , Leonardio	erai Home, l vn, Maryian	P.A. d 20650	
	200			23a. Part1. Enter the diseas or shock, or heart failure. ist	complications that	it caused the	th. Do not er	ter the mode of dyi	ng, such as cardiac	or respiratory arrest		Approximate Interval Between
	Physic	ian		Immediate Cause (Final disease or condition	As a			c snac				Onset and Death
	/Med			resulting in death)	a					1.120		
	Exam			Sequentially list conditions.	b			e neal	rt fai	1912		1544
	D D	₩.	Examiner	Sequentially list conditions, I arry, leaving to in reclaid cause. Enter Underlying Cause (Disease or injury		non e ele voli ol T 2 Vi	soquenes of)	a. la	Nyo card	100 into	521 (17 cm	17945
	ecute	-tran	каш	that initiated events resulting in death) Last	c. No	1-00						
	8760, cate ba executad ohysician and	burial	E E	,		1) KYS						
	387 cate	the :	dical		d	7 (4 1 ((5 0-0) (112 547			
	X 6 cartific	Se as	Physician/Me	IF FEMALE:	23c. If yes, o	outcome of pre	egnancy				23d. Date of	deliven
NO	Box eath cart	for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live	e birth 2 □ f ignant at time	Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	y		Month Month	Day Year
GATTON	P.O.	ched	ysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unl							
d.	_ = 6	e deta	by P	Part II. Other significant condition	ns contributing to	death but not	resulting in the	underlying cause giv	ven in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
NE	rds quire n sig	ğ :								1 ☐ Yes	2 □ No 3	Probably 4 Unknown
LORRAINE	C 3 D	ous :	Completed							24a. Was an	24b. Were	autopsy findings available
ORF	Rec The law Ite has b	age	mo							autopsy performe 1 ☐ Yes 2 ☑	d? death	to completion of cause of ? 'es 2 👺 No
	Vital F vicien: Th certificate	for, p	Bec	25. Was case referred to medical					26. Place of Deat	h (Check only one)	3140	03 289110
IE.	of Vital Records, Physicien: The law requires rthis certificate has been sign	direc	0	examiner? 1 □ Yes 2 🌠 No	Hospital:	Minpatient :	2 ER/Outpatie	ent 3 DOA Ott	her: 4 Nursing Ho	me 5 Residence	e 6 □Other (S	(pecify)
ABBIE	Vision of Vita Attending Physicien: r death. ector: After this certific	neral		27. Manner of Death 1/SNatural 5 ☐ Pendin		te of Injury onth, Day Yea	28b. Time (ry at	28d. Describe how		
	Division or Attending after death. Director: Atta	he fu	Certification;	2 Accident investig	ation				Yes 2□No			
	Division of artendate death	by t	ţį.	3 Suicide 6 Could a determ	289, Pla	ice of Injury - A	At home, farm, si	treet, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
	itel of urs af	led ir	Ö	1								
	Hospitel Hospitel Funerel	tely fi	edical	(Check only 2 Medical	Examiner: On the	basis of exam			me, date and place, opinion, death occur			
	To the Hospitel of within 24 hours a To the Funerel C	completely filled in by the funeral director, page 2	Med	one) 29b. Signature and title of certifier	and ma	anner stated.		29c. Licens	se number	204	. Date signed (Mo	onth Day Year)
	5 ¥ 5	8		Nevs Signature and time of termine					61917		igust 9,	
	gre			20 Name and address of the	who age store t	was of all it	(1) (2)-> ==		, , , ,		J	
	· U			30. Name and address of person DHANANJAY BH			(Item 23a) (Type LSSOC HO		MD 2063	6		
		Stat	e	31. Date filed (Month, Day, Year)	32	. Registras S		<u> </u>	2000			
			¥.	Alic	1 1 2005		20	Too Me	,			

DHMH 17 Rev 1/2001

			For State (artment of Health and M rtificate of Death		giene 2005 2	7267
			Decedent's Name (First, Middle, Last)			2. Date of Dea Month	ath Day Year	3. Time of Death
	Physici: /Medic		Alvin Joseph Guffey		,	August	5, 2005	8:41 p ^M
	Examin		4a. Facility Name (If not institution, give street and no	umber)	4b. City, Town, or Location of Death		4c. County of Death	
			39095 Deer Lane 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Mechanicsville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	St. Mary'	S ace (State or Foreign
	Funeral Director	İ	5. Social Security Number 6. Sex 411-68-5309	64 Yrs.	Months Days Hours Min.	(Month, Day	7, Year) 7, 1940 Indi	y) ·
			Usuel Residence of Decedent	04		Dec. 27	, 1940 IIIdi	ana
	nylani how		10a. State 10b. County	10c. City, Town or Lo	ocation		100	d. Inside City Limits
	Se-1 s	cto	Maryland St. Mary's	Mechanic				1 ☐ Yes 2 X No
	with th	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Countr	y?
	s 23s	eral	39095 Deer Lane	cedent Ever in U.S. 13.	20659 Was Decedent of Hispanic Origin? (Sp	noify Voc or No	U.S.A.	n Indian
	72 hours after death with the Maryland Insture!; or Items 23e or 28e-f show diest Examinational be notified at	by Funeral	Armed F	orces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, et	tc.
036	urs at	by	3 Widowed 4 Divorced If Yes, G	IVE	1 ☐ Yes 2 No Specify:		Specify: White	<u>a</u>
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed	16a. Dece	dent's Usual Occupation	ina	16b. Kind of Business/indu	istry
2	ithin nan nan	nple		(1-4or 5+)	kind of work done during most of work DO NOT use retired) Counselor	9	71	
2	lled w tygier her ti		17. Father's Name (First, Middle, Last)			a (First Middle	Education Maiden Surmame)	
anc	ntal Hed of	Be c	Wayne W. Guffey				waldeli Sulliame)	
Maryland 21215-0036	should od Me mark matic	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	Ruth K. ng Address (Street and Number or Rur		or, City or Town, State, Zip C	Code)
Z	od 2 s lith ar 27 le r trau		Judith Guffey/ Wife		5 Deer Lane, Mech			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturet, or Items 23a or 28e-f show any injury or other traumatic event, the Madical Examination and be nutified at once.		20a. Method of Disposition	20b. Place of Dispo		Date	20c. Location - City or Tow	
Ē	Page nent o nt: If rry or		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	1 State	femorial Gard 8-1	0-2005	Leonardtown.	Maryland
alti	permit. Departminports Imports any inju		21. Signature of Funeral Se vice ticensee	22	2. Name and Address of Facility $ { m Br} $	insfield	i Funeral Hom	ne, P.A.
<u>m</u>	8 Q E # 9		Edward N. Brinsfield, J.	c. M00052	22955 Hollywood R	oad, Lec	onardtown, MD	20650
'n,			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not enteach line.	ter the mode of dying, such as cardiac	or respiratory are		Approximate Interval Between
	Physician:	F 16	Immediate Cause (Final disease or conditiona.	Colon	Cancer			Onset and Death
	/Medical Examiner		resulting in death) Due to	(or as a consequence of):				3 1
		<u></u>	Sequentially list conditions, b. Due to	(or as a consequence of):				
	nted Insit	mine	cause. Enter Underlying	. (4				
Ć,	exection and ital-tra	Examiner	that initiated events c. resulting in death) Last Due to	o (or as a consequence of):				
8760,	death certificate be executed e attending physician and of for use as the burral-transit	dicai	d					
9	ng ph	Med	IF FEMALE:					
Вох	death certific attending pl	Physician/Me	23h Was decedent pregnant 23c. If yes, o	utcome of pregnancy birth 2 Petal death 3	Ectopic pregnancy		23d. Date of delivery Month D	y Day Year
0.		/sici	1		Other (specify)		No.	2,
<u>G</u>	that the de ed by the detached	Ph	Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause given in Part I.	23e. Did to	bbacco use contribute to the	cause of death?
ds,	se us	d by		•	,,,	1 🗆 Y	es 2 No 3 □ Probat	bly 4 □Unknown
200		lete				24a. Wasa	an 24b Were autops	sy findings available
Re	The law sete has b page 2 sl	Completed				autop: perfor	med? prior to comp med? death?	pletion of cause of
tal	ician: Th certificete rector, pag	a	25. Was case referred to medical		26. Place of Deat		/	No No
of Vital Records	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 M No Hospital: 1 ☐	Inpatient 2 ER/Outpatie	Other	,	lence 6 Other (Specify)	
0 1	ng Pth fter th neral		27. Manner of Sath 28a. Date (Mo	of Injury nth, Day Year) 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe h	ow injury occurred	
Sio	tendi leath. tor: A the fu	cati	Accident investigation		M 1 Yes 2 No			
Division	l or Att after d Direct I in by	Certification:	determined 200. Flat	ee of Injury · At home, farm, st ding, etc. <i>(Specify)</i>	reet, factory, office	28f. Location (S City or Tow	Street and Number or Rural I m, State)	Route Number,
	Hospital or Attending 24 hours after death. Funeral Director: Afte tely filled in by the fune		29a. Certifier Certifying Physician: To the	ne best of my knowledge, deat	th occurred at the time, date and place,	and due to the o	rause(s) and manner as stat	ted
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only /2 Medical Examiner: On the		ivestigation, in my opinion, death occur			
	To the h within 24 To the f complete	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Da	
)	WE		Miletoku MI)		D46246	7	August 8.	2005
2	10		30. Name and address of person who completed car	use of death (Item 23a) (Type,	Print)	7LI)O12	August 8, o	3
	Sta Registr		31. Date filed (Month, Day, Year) 32. AUG 1 0 2005	Registar's Signature	ful			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Dourley 1005 AM 2005 John August /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hospital DALTIMORE Hopkins Johns If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months 1**M** M 2□ F 59 Yrs Felton, DE 221-28-8023 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 4/ is marked other than "natural", or Items 23e or 28e-f shot other traumatic event, Ite Modical Exactive fourties actified at iola 1 ☐ Yes 2 No Director DE Kent 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 448 19979 USA VANS Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours affer □Yes 2X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) miner torse Horse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or own, State, Zip Code) 19a. Informant's Name/Relationship (Type, W. Evans Oset 1010 tina 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of Hi Important: If iter any injury or oth 1 Burial 2 Cremation 3 Removal from State Hus 10,2005 LAPITOL 5 ☐ Other (Specify) ` 4 ☐ Donation 22. Name and Address of Facility 5 21. Signature of Funeral Service Licensee once DE 19904 Dover OCDERT 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia Physician day /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or ling), that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-fransit The law requires that the death certificate be executed the attending physician and hed for use as the burial-frar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the funeral director, page 2: 1 Yes 2 1 2[VNo 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 2 No 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 0 this Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No M 24 hours affer death. 9 Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune complefely f To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 Munoz, Daniel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Munoz, MD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Baltimore, MD

600 North Wolfe Street

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Stata Registrar Amended 1. 8/15/05 per Dr. Certificate of Death CCHD AS 1. Decedent's Name (First, Middle, Last) 2. Date of Death Stanley Mark Grande Month Day Year **Physician** 15-16 A M 701. GRANDE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAITIMORE of MARY LAND MEDICAL CENTER UNIVERSHY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 1, 1947 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 17€ M 2□ F Minnesota 58 219-48-6181 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Denton Caroline Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country America United States of 21629 9250 Andersontown Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐ Yes 2 Yes, Give 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates: Caucasian Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Repair Business
Music teacher 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cameras & Optical Elementary/Secondary (0-12) College (1-4or 5+) 4 Education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Ann Kaster Stanley Joseph Grande ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21122 19a. Informant's Name/Relationship (Type, Print) 1222 Holmespun Drive, Pasadena, Maryland daughter Lauren Grande 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dover, Delaware Capitol Crematory 8/7/2005 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Moore Funeral Home, P.A. 21 Signature of Funeral Service License 12 South Second Street, Denton, Maryland 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HEOLEN ENMARKE Immediate Cause (Final disease or condition resulting in death) HEMATOMA SUBDURAL Due to (or as a consequence of): RHARD DA Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural

burial-transit physician as the b esn the

certificate has

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e Hospitel or Attending Pi 24 hours after death. e Funeral Director: After ti

24 hours a

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Box 68760,

P.O.

Division of Vital Records,

Physicien:

Funeral

Director

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Items 23e

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the Maryland

death

1 and 2 should be filed within 72 hours after (Health and Mental Hygiene. 5m 27 is marked other then "neturel", or Itel

permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any njury or other treu

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

5 Pending investigation

28

28a. Date of Injury (Month, Day Year) 28b. Time of Injury Unknown 105 Plac of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 🛣 No

Subject fell

28f. Location (Street and Number or Rural Route Number, City or Town, State) DENTON 50 ANDERSON TOWN Ra. MD

29a. Certifier

2 Accident 3 Suicide

4 | Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and married stated

BUTHEL St. BOLLIMONE

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

MD

6 Could not be

he and address of person who completed cause of death (Item 23a) (Type, Print)

16537

JOSEPH 31. Date filed (Month, Day, Year)

105 32. Registrar's Signature

State Registrar AUG 1 5 2005

Home

			For State Registrar	State of M		nd / Depa	artme		ealth	and M	-		9		. 7.0
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م	1 an Heali Sem 2		20a. Method of Disposition	3011	20b. F	L Z 3 / U Place of Dispos			ane		nsboro,			21639 or Town, State	
Baltimore,	ages ont of tt: If if		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		(cemetery, cren	natory or	other place	′ I						
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	within To th	Me	29b. Signature and title of certifier	0			29	c. License	number		2	9d. Date	signed (Mor	th, Day, Year)	
·			Kener	Sell	22	M		D3	137	76		8-	9-0	5	
			30. Name and address of person who d	completed cause of de	ath (Item	23a) (Type, P	Print)	2 -	-		~	1	/ -	-	
			James SI	Ues, 9	120) M	erti	ct	5	t	1201	IL	DV 1	72	
2	Stat Registra		31. Date filed (Month 18 Year) 21	32. Figistra	r's Signa	A A									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Virginia Green **Physician** AUG. 2005 Dorothy 2:25PM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Denton Caroline Ruxton Health of Denton If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 11/04/34 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1 ☐ M 2 🗑 F Yrs. 218-40-6274 70 Maryland Director Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County is marked other than "neturet", or items 23a or 28e-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Completed by Funeral Director MD Caroline Federalsburg 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Shady Grove Lot 14 Ischer Rd. 21632 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Deputment of Health and Mental Hygiene.

Important: If item 27 is marked other than "neturelt, or Item any injury or other traumatic event, Ite Medical Exercises once. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Towers Mary Elizabeth Giffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21632 19a. Informant's Name/Relationship (Type, Print) Shady Grove Lot 14 Ischer Rd., Federalsburg, MD Ralph G. Green/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Eastern Shore Veterans Cem 08/16/05 Hurlock, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Gskew 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL NFARCTION **Physician** disease or condition resulting in death) /Medical CADIOVASCHIK! Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Records, P.O. by the 9 Unknown signed I I be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Sknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No autopsy 1 Yes 25 No Division of Vital or Attending Physicien: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No 2 To the Hospitel or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in proceedings. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier TE NIDING of person who completed cause of death (Item 23a) (Type, Print) 321 BLOOMINGSA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 15 Registrar 2005

			1 - For State Registrar	Sta	ate of Ma	aryland		artment of F		ind M			5	27272		
п	Physic	ian	Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month		Year	3. Time of Death		
	/Medi		Archibald			Gra	у				August	Day 3 2	005	7:00 a ^M		
	Exami	ner	4a. Facility Name (If not institution		and number)			4b. City, Town, o		f Death		4c. County	of Death			
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ŀ	Funeral Director		216-18-5669	1 XM 2		81	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day Oct. 1	Year)	9. Birth	olace (State or Foreign		
			Usual Residence of Decedent			01					OCC. I	0,1923	ren	nsylvania		
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	Ba-f :	Director		Arund	e1		Annap	olis						1 ☐ Yes 2X No		
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Baltimore, Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 Is marks other traumatic		Susan Schmalf		r)		g Address (Street and Number or Rural Route Black Walnut Court,									
ore,	σ O		20a. Method of Disposition				ce of Dispo	sition (Name of matory or other place	a)			20c. Location -				
Ē	Pages ment of I ant; If its ury or o		1 X Burial 2 □ Cremation `4 □ Donation 5 □ Other (S		Il from State	i		Cemeter		3-6-2	2005	Annapo	lis,	MD		
alt	permit. Page Department of Important; If any injury of		21. Signature of Funeral Service	icensee			22	Name and Address	s of Facility	ara1	Ното					
	<u></u> <u> </u>		77-7.0					12 Klag	ета Ал	venu	e, Anna	polis,	MD 2	1401		
E			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications only one caus	s that caused se on each lin	the death. ie.	Do not ent	er the mode of dying	g, such as ca	ardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Caeduac Arryttmurg											Onset and Death		
	Examiner			•	Due to (or as	a conseque	nce of):	(`							
		Je.	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Water for as a	conseque	nce of):						-			
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events										- 1			
Ó,	ate be executed hysician and the burial-transit		resulting in death) Last													
8760,	cate be executed physician and the burial-transit	Physician/Medical		d												
9		/Mec	IF FEMALE:	220 16:00												
Вох	atter for u	lan	23b. Was decedent pregnant in the past 12 months?	1	es, outcome o Live birth Pregnant at	2 🗌 Fetal de	Ectopic pregnancy		23d. Date Mon	ry Day Year						
o.	5 a 5	nyslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		U <i>n</i> known	ume or dear	tn 5L	Other (specify)								
S, D	The law requires that the tte has been signed by th page 2 should be detache	by Pl	Part II. Other significant condition	ns contributin	ig to death bu	ıt not resulti	ng in the ur	nderlying cause give	n in Part I.		23e. Did tob	acco use contri	oute to th	e cause of death?		
rds	tw requires that been signed I should be det		faelee	10	ltoric	le					1 □ Ye	s 2 🗆 No	3 Prob	abiy 4 Unknown		
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m m		Completed									autopsy perform	Legoγ? de	ath?	npletion of cause of 2 No		
Vital Record	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?						26. Place o	f Death	Check only one					
	ys dir	2	1 Yes 2 No	Hospital	1 LI Inpatier		VOutpatien		4 LINUIS)		
- C	ding After funer	lon	27. Manner of Death 1 Natural 5 □ Pendin	9	Date of Injury (Month, Day	Year) 28	Bb. Time of Injury	28c. Injury Work M 1 1 7			3d. Describe ho	w injury occurre	d			
Division of	or Attendiafter death. Director: A in by the fu	ficat	2 Accident investig 3 Suicide 6 Could n	ot be	Place of Iniu	rv - At home	e farm stre	eet, factory, office	es 2□No	-	Rf Location (Str	eet and Numbo	or Pura	Route Number,		
5	al or A after Direction by	Certification:	4 Homicide determine	neu	building, etc.	(Specify)	-,, 5	ot, tablery, billog		1	City or Town,	State)	Or Mulai	noute Number,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier Certifyin	Physician:	To the best o	f my knowle	edge, death	occurred at the time	e, date and p	place, an	d due to the ca	use(s) and man	ner as sta	ated.		
	the Hin 24 the Fi	ledical	one)	xaminer: On	the basis of a manner stat	examınatior	and/or inv	estigation, in my op	inion, death	occurred	at the time, da	te and place, ar	d due to	the cause(s)		
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	,				29c. License	number		29	d. Date signed	(Month, E	Day, Year)		
ł			CH						570			8.3.	25			
			30. Name and addless of person v	0.000	d cause of de	ath (Item 23	3a) (Type, F	Print)	11.0	4	71.10	, 1		nD. 21401		
	Sta	te.	31. Date filed (Month, Day, Year)	opra	32. Sgistrai	r's Signature	UK	lagery	HUT .	ヤノ	> Hnr	apoli	Sir	ND. 21401		
	Registr	_	AUG 0 4	2005	A second			rock!								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 5 Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** ALTON GEORGE HOUSER 05.05 Angus 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON 8. Date of Birth (Month, Day, Year) JAN. 19, 1 9. Birthplace (State or Foreign 6. Sex 1 2 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Yrs. 220-10-4556 87 T918 MARYLAND Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1XYes 2 ☐ No Funeral Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 16 KNODE CIRCLE teme 23e 21713 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 1941— 1 ØYes 2 □ № If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes X No Specify: þ Specify: 3 Widowed 4 Divorced WHITE Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LAB TECHNICIAN permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Importent: If item 27 is marked other th any injury or other treumatic event, that once. NATIONAL HEALTH ORG. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HARVEY HOUSER MARYBELLE DAUGHERTY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BETTIE J. HOUSER, SPOUSE 16 KNODE CIRCLE, BOONSBORO, MARYLAND Baltimore, 20a. Method of Disposition
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State BOONSBORO CEMETERY AUG. 13, 05 BOONSBORO, MARYLAND ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sure of Turiers Santo Licensee 22. Name and Address of Facility 7606 OLD NATIONAL PIKE A. Zimmerman BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumonia 2 weeks /Medical Due to (or as a cons Examiner obstructive lung Disease Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Somary artery brease Atrial Frontlation. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Onknown ate has been si page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan 2No 1 Tes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 SNatural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title dicertifier D44996 20 311 Coppans Rd Reenstono Mp 217/3 30. Name and address of person w ause of death (Item 23a) (Type, Print) MD 24-7+1 31. Date filed (Month. State Registrar

	1 - For State Registrar	State of Maryland		ment of H icate of L			iene	15 27275
Physiciar		•		-	_	2. Date of Deat Month	h Day	3. Time of Death
/Medica Examine			4b	. City, Town, or	Location of Death	August 5	4c. County	
Funeral	Washington Cou 5. Social Security Number 6. S	nty Hospital Sex 7. Age (In yrs. Ia	st birthday) If	Hage:	rstown If Under 24 Hrs.	8. Date of Birth	Wash	ington County 9. Birthplace (State or Foreign County)
Director	2.9 31 3112	Sex 7 7. Age (In yrs. Ia 11 XM 2□ F 66	Yrs.	onths Days	Hours Min.	8. Date of Birth (Month, Day, Nov 10	1938	Maryland
yland	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	on				10d. Inside City Limits
with the Marylan to 286-1 show be notified at	Maryland Washi	ngton	Hagerst		·			1 ☐ Yes 🛂 No
1215-0036 within 72 hours after death with the Maryland ene. than "naturel; or items 23a or 28e-1 show the Modesal Examiner must be notified at	10e. Street and Number 11826 Peacock	Frail	1	Of. Zip Code 2°	1742	10	og. Citizen of V United	What Country? d States
of intermet in the state of the	11. Marital Status	12. Was Decedent Ever in U.S Amed Forces?	. 13. Was	Decedent of Hi s, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc.
15-0036 72 hours after death w "naturel; or items 23a sideal Examiner must I	3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:	1	Yes 2⊠ No	Specify:			White
ed within 72 hou signed within 72 hou signed than instanted it, the Missical Ed.	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decedent	s Usual Occupa	ation during most of worki	ng	16b. Kind of Bu	usiness/Industry
212. d within giene. or than	Elementary/Secondary (0-12)	College (1-4or 5+)		ice Offi			Americ	can Legion
and The file that Hy ed othe event.	17. Father's Name (First, Middle, Last				18. Mother's Name	(First, Middle, N		
aryla should I may Men Men Men Men Men Men Men Men Men Men	Frank Harsh 19a. Informant's Name/Relationship	Туре, Print)	19b. Mailing Ad	idress (Street a	Mary and Number or Rura	May Ha	rsh City or Town,	State, Zip Code)
and 2 and 2 lealth m 27 ls	Andrea L. Harsh							yland 21742
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Importent: If item 27 is marked other the "naturel", or importent: If item 27 is marked other the Medical Examn once. To Re Commissed Examn	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	TURITIONAL ITOITI STATE	ce of Disposition metery, cremator		1	ľ		City or Town, State
Baltir Permit. F Departme Importen eny injur	21. Signature of Funeral Service Lice		st Haver	me and Addres		0-2005		stown Maryland Funeral Home
00 80558	1 Selector +	Ling	133	1 Easte	ern Blvd.	N. Hage	rstown	Maryland
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/Medical Examiner	disease or condition resulting in death)	Due to (or as a conseque	ince of):	1377U	CTIVE H	MUNDA	<u>cg 1/150</u>	e Ase
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8760, cate be executed bhysician and the burial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
18760, cate be extended by sician at the burial-dical Ex		Due to (or as a conseque	nce of):					
rtificate ng phy as the	IF FEMALE:	_ d	-					
S, P.O. Box 68 es that the death certification by the attending plant be detached for use as a by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	eath 3 Ecto	pic pregnancy er (specify)			23d. Date Mon	e of delivery hth Day Year
P.O. Both the death of the detached for physicia	1 Yes 2 No 9 Unknown	9□ Unknown	5 0 0	er (specily)				
Division of Vital Records, P.O. or Attending Physicien: The law requires that the dater death. Director: After this certificate has been signed by the line by the funeral director, page 2 should be detached ertification: To Be Completed by Physicertification:	Part II. Other significant conditions of	contributing to death but not result	ing in the underf	ying cause give	en in Part I.			ibute to the cause of death? 3 ⊕Probably 4 □Unknown
al Record The law requir cate has been single as should						24a. Was an	24b. W	Vere autopsy findings available
The lav						autopsy perform 1 Yes 2	ed? di	rior to completion of cause of eath?
f Vital Re ysicien: The I is certificate ha director, page	25. Was case referred to medical examiner?	Hospital:			26. Place of Death	Check onl one		
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Division cite or Attending Prisa after death. The after death. The distribution of the free free free free free free free fr	4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, rarm, street, r	астогу, опісе		City or Town,	State)	er or Rural Route Number,
Hospi 4 hou Funet ely fill		niner: On the best of my knowledge. On the basis of examination and manner stated.	n and/or investig	ation, in my op	inion, death occurre	d at the time, dat	e and place, a	nd due to the cause(s)
To the within 2 To the complete	29b. Signature and title of certifier	7/		29c. License	number	29	d. Date signed	(Month, Day, Year)
	30. Name and address of person who	completed cause of death (Item 2	3a) (Type, Print	POD	5599	4	8/6/	105
0H9+1	31. Date filed (Month, Day, Year)	HAM 11110 A	MENTAL	CAMPL	onumber 5599	43 H	ACENITO	1741
State Registrar	31. Date filed (Month, Day, Year) AUG 0 9	32. Registrar's Signatur	the paper	٨				

		-	For State Registrar	State of Ma	aryland		artment of H		ınd Men		iene	5	27276
			Decedent's Name (First, Middle, Last)	11 -	-3	1			Date of Deat	Day 2005	(ear	3. Time of Death
	Physicia /Medic	al	Honer	Lloyd	Han	rydir	J		, ,	1945t	11		7:42 PM
	Examin	er	4a. Facility Name (If not institution, give		nter	-	4b. City, Town, or		min St	2	4c. County of	Col	\
	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. las	t birthday)	If Under 1 Year	If Under 2	24 Hrs. 8. [Date of Birth	Voar) S		lace (State or Foreign
	Director		229-30-9094	M 2□F	78	Yrs.	Months Days	Hours	Min. Ju	ne 9,	1927	Vir	ginia
	and W	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	ocation					1	0d. Inside City Limits
	Maryl f sho	ţō	Maryland Carrol]			Union Br	ridge					1XYes 2 ☐ No
	h tha	irec	10e. Street and Number				10f. Zip Code			1	0g. Citizen of Wh	at Cour	ntry?
	ath wil	rai	530 Shriner Ct					217			U.S.A. 14. Race - American Indian,		
	er de	nue	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕅			Was Decedent of Hi If Yes, specify Cuba	ispanic Orig n, Mexican	gin? (Specify i, Puerto Rica	Yes or No- in, etc.)		White,	
920	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 No	Specify:			Specify:	Whit	:e
21215-0036	72 hours after death with the Maryland Insture); or Itams 23a or 28a-f show diest Eventrat must be notified at	Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad			(Give	dent's Usual Occupa	during most	t of working		16b. Kind of Busi	ness/In	dustry
121	filed within Hygiene. other than "	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired carper	•			cons	truc	tion
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ılan	should be tand Mantal I s marked o	To Be	Dewey Hansbro	ıgh					Sadi	e Shif	lett		
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e, N	1 and Health Ism 27 Sther to		Alice Hansbrough/ 20a, Method of Disposition	wiте	20b. Plac	e of Dispe	Shriner Ct osition (Name of		Un I On Date		9, MD 21; 20c. Location - C		own, State
nor	ages ant of it: if it y or o		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		1		matory or other plac netery		8/5/20	05	Keysvil'	le.	MD
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		21. Significant of Funeral Service Licen		Cer	2	2. Name and Addres	ss of Facilit	y Hartz	ler Fu		ome	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cause	d the death.	Do not en							Approximate Interval Between
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	outad ad ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events										
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8760	cate b physic the b	dica		d								-	
Box 6	death certificate be exacutad e attending physician and nd for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			¬r. :		23d. Date of delivery				
	e death he atte	Physiclan/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant a 9 □ Unknown			□Ectopic pregnancy □ Other (specify)				Monti	h	Day Year
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CO	aw require as been sig 2 should b	ompleted								24a. Was a		ere auto	psy findings available mpletion of cause of
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Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			oth Oth	00	of Death (C				
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ion	Attending Price death. ector: After by the funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay rear)	Injury	M 1 🗆	Yes 2	No				
Division	il or Attend after death Director: /	Certification:	3 Suicide 6 Could not be determined	286. Place of III	jury - At hom tc. (Specify)	e, farm, s	treet, factory, office		28f.	Location (SI City or Town	treet and Number n, State)	or Rura	al Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled in		29a. Certifier 1 ☑ Certifying Ph	ysician: To the best	of my know	ledge, dea	th occurred at the tin	ne, date an	nd place, and	due to the c	ause(s) and man	ner as s	stated.
	To the Hospital within 24 hours a To the Funerel I completely filled	edicai	(Check only 2 Medical Examone)	niner: On the basis of and manner s		on and/or in	nvestigation, in my o	pinion, dea	ath occurred a	at the time, d	ate and place, an	nd due to	o the cause(s)
	vithi To tl	Σ	29b. Signature and title of certifier	Sin CM	ell.	4.0	29c. Licens	e number	742		29d. Date signed		
•	WIL			7	donth (tree	120) (August	1/	2005
	4		30. Name and address diperson who	completed cause of 29 S 32. Regist	SPN2	(Type	R. SUP?	307 1	- Smi	nsper	WD :	2115	7-
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	Regist	rar	AUG U 8	2003	THE .	10	A STATE OF THE PARTY OF THE PAR						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yee Physician Willie Mae Hicks 3, 2005 4:00P August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Millenium Nursing Homes Forestville Prince George If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 17, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2€3¥ Months 75 243-42-0334 1930 North Carolina Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23s or 28s-f show any injury or other traumetic event, the Modical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County New York txFlYes 2 □ No Kings Brooklyn **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 249 Thomas S. Boyland St. Apt. 16-A 11233 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No **Black** Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12th Factory Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlie Felton Johnetta Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16121 McConnell Dr. Upper Marlboro, MD. Thelma Wiggins Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Aug. 8, 2005 Clinton, MD. 4 ☐ Donation 5 ☐ Other (Specify) Pope Funeral Homes 22. Name and Address of Facility 21. Signature of Euneral Service/Ci 5538 Marlboro Pike Forestville, MD. ina 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) enolarunom SMORY **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnanting the past 12 months?

1 1 Yes 2 1 No 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day ŏ 4☐Pregnant at time of death 5 Other (specify) P.0. the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 1 Yes 2 1 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Certification: To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10055314 818105 DICON ICWO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sylvester Okonkwo, M.D., 6192 Oxon Hill Rd. Suite 507, Oxon Hill, MD. 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 Month Physician August 2, Rosemary Boyd - Ham 7:45a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 11110 Pompey Dr. Upper Marlboro Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours | Min. (Month, Day, Year)
March 14,1948 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🖳 F 216-50-9698 57 Charlestown, Md Director Usual Residence of Decedent within 72 hours etter death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1□Yes 2□No Funeral Director Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11110 Pompey Dr. United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Y No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry th and Mental Hygiene.

7 is marked other than "
froumatic event, the Ma College (1-4or 5+) Elementary/Secondary (0-12) D.C. Government Secretary 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) d 2 should be fi h and Mental H 7 is marked off William H. Boyd Martha Dyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent: if item 27 is
any injury or other treu Shirley Machonis / Sister 11110 Pompey Dr. Upper Marlboro, Md. 20772 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Aug. 6, 2005 Clinton, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liensee ²²Alexander S. Pope Funeral Homes, P.A. 201085 5538 Marlboro Pike/Forestville, Md. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** VCUIZN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): .O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 ☐ Yes 2 🕱 No certificate 1 ☐ Yes 2 X No within 24 hours etter death.

To the Funerel Director: After this certific completely tilled in by the tuneral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomscide ō Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifie D0052999 ranumay 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURRATTS ROAD CLINTON MD 20735 KAHIMIAN MD 7501 Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year HERBERT THOMAS JUMP AUGUST 08 2005 12:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WILLIAM HILL MANOR EASTON TALBOT If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Director 144-10-0470 89 Yrs. 1916 Royal Oak, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show item 27 is marked other then "naturel", or items 23a or 28e-f show other treumatic event, the Madical Examination ust be recilied at Director 1 ☐ Yes 2X No MARYLAND TALBOT ROYAL OAK 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 6763 THORNTON ROAD, P.O. Box 132 U.S.A.

14. Race - American Indian,
Black, White, etc. by Funeral <u> 21662</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Telephone Repairman Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental I George I. Jump ဥ Bessie M. Colburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is any injury or other tree Diane E. Minear / Daughter 140 Rocklawn Avenue, Attleboro, M. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Spring Hill Cemetery | 08-12-05 Easton, Maryland ²² Name and Address of Facility
Fellows, Helfenbein and Newnam Funeral Home, PA
200 S. Harrison Street, Easton, MD 21601 21. Signature of Funeral Service Licensee -TOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonic 0073 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detact Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 2 No To the Hospitet or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner - Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 atural 5 Pending 1 Yes 2 No hours after death. 2 Accident within 24 hours after deat To the Funerel Director: 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 289. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) lilled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of aestifier 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) K. Helsaseck MO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Robert Irvin Johnson, Jr. 2, 2005 August 1:58 P. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1981 Dominoe Road Annapolis Anne Arundel 5. Social Security Number 219-64-5987 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 4/22/55 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days Hours 1 JM 2 □ F 50 Yrs. Director Cheverly, Md. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural; or Items 23s or 28s-1 ehow 10a State 10h. County 10c. City, Town or Location 7 is marked other then "natural", or itema 23s or 28s-f show traumatic event, the Modical Examination usit by motified at 10d. Inside City Limits 1⊠Yes 2 No Director Md. Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1981 Dominoe Road 21401 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert I. Johnson, Sr. Sylvia Louise Spriggs 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Curtis/Sister other 2607 Kinderbrook Ln., Bowie, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8-6-05 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ö pernit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. Beltsville Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 Lau 23a. Part1. Inher the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Diabetes Mellitus Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Hypertension burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical ď IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ihis 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending death. M 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and thre of certific 29c. License number 29d. Date signed (Month, Day, Year) D31528 August 4, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) AUG 0 8 2005

DHMH 17 Rev 1/2001

20785

Margaret Akpan, M.D. 6128 Landover Road, Cheverly, Md.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Allison Carol Jimenez 2:30P M 2, 2005 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7340 Point Patience Way Elkridge Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF Director 219-17-0833 32 Yrs. June 29, Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits worke ?7 ie marked other than "natural", or iteme 23a or 28a-f ehov traumatic event, it e bledical Eracia se mast be notified at 1 ☐ Yes 2 XNo Director Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7340 Point Patience Way 21075 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. withIn 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be marked o Russell Wayne Fritz Carol Lee Hoshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a importent: If item 27 is any injury or other training. Elvin H. Jimenez/husband 7340 Point Patience Way Elkridge, MD 21075 20a. Method of Disposition
1 □ Burial 2 ⚠ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State August 3, * 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 2005 Odenton, Maryland 21. Signature of Funecal Service Licensee, Coing Home Cremation Service P.O. Box 784 Beverly よし MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OLIGO DENORO GLIOMA **Physician** YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list constitute if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ettending physician and for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No After this certification Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Attending 5 Pending 1XXVatural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or within 24 hours a To the Funerel D 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 123683 MO August 3, 2005 completed cause of death (Item 23a) (Type, Print)

SMAN HD Johns Holking Houping BARTHOSE strar's Signature State Registrar

		, 101	partment of Health and N <i>ertificate of Death</i>	ental Hygie	21115 27282		
Physic /Medi		1. Decedent's Name (First, Middle, Last) Earnest H. Jordan		2. Date of Death Month July 30	Day Year 2005 3. Time of Death 0600 M		
Examination Funeral Director	ner	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center 5. Social Security Number 6. Sex 1 NM 2 F 7. Age (In yrs. last birthda	Months Days Hours Min	8. Date of Birth (Month, Day, Y	4c. County of Death Anne Arundel 9. Birthplace (State or Foreign Country)		
ט	<u></u>	406-26-6574		∬an. 14	1927 Kentucky 10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
with the M a or 28a-f	Directo	Maryland Anne Arundel Arnolo 10e. Street and Number	10f. Zip Code	10g	Citizen of What Country?		
rs after death	by Funeral Director	912 Mago Vista Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 12. Wes Decedent Ever in U.S. Armed Forces? 12. Wes Decedent Ever in U.S. Armed Forces? 14. Was Decedent Ever in U.S. Armed Forces? 15. Wes Decedent Ever in U.S. Armed Forces? 15. Wes Decedent Ever in U.S. Armed Forces? 16. Wes Decedent Ever in U.S. Armed Forces? 17. Wes Decedent Ever in U.S. Armed Forces? 18. Wes Decedent Ever in U.S. Armed Forces? 18. Wes Decedent Ever in U.S. Armed Forces? 19. Wes Decedent Ever in U.S. Armed Forces? 19. Wes Decedent Ever in U.S. Armed Forces? 19. Wes Decedent Ever in U.S. Armed Forces? 19. Wes Decedent Ever in U.S. Armed Forces?	21012 3. Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: Black		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Inlury or other traumatic event, It a Madical Examiner must be natified at another.	Completed t	15 Decedent's Education 16a De	cedent's Usual Occupation verkind of work done during most of work p. DO NOT use retired) Maintenance	ing 16	Sb. Kind of Business/Industry		
yland A buld be filed a Mental Hygie arked other atic event, It	To Be Co	17. Father's Name (First, Middle, Last) Jake Jordan	18. Mother's Nam	e (First, Middle, Mai a Diller	,		
and 2 should and 2 should lealth and Men m 27 is marke her traumatic	-		ailing Address (Street and Number or Rur				
antifficacy mit. Pages 1 a partment of Her portant: If Item y Injury or othe		20a. Method of Disposition 20b. Place of Dis		Date 200	c. Location - City or Town, State		
Defutil: Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not a	22. Name and Address of Facility Wm. Reese & Son 821 west St. An	s Mortua napolis,	ry . P.A. Ma. 21401		
Physician /Medical Examiner	, L	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate			Interval Between Onset and Death		
cate be executed physician and the burial-transit	dical Examiner	if any, leadin, to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):					
ires that the death certifications that the attending p of the attending p do be detached for use as	Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year		
w requires that been signed be should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of death?		
al neco	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 12 Yes 2 No		
To the Hospital or Attending Physician: The law requires that the death certification is thours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Nopatient 2 ER/Outpat 27. Manner of Death 1 Natural 5 Pending 2 Accident Novestigation	ient 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 28d. Describe how i	e 6 □Other (Specify) njury occurred		
ital or Attend us after death ral Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, S			
the Hosp hin 24 hou the Fune npletely fil	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	ed at the time, date	and place, and due to the cause(s)		
viti Too	-	29b. Signature and title of certifier M.D.	29c. License number	7 290.	Date signed (Month, Day, Year) 7 (3 0 (0 5		
		30. Name and address of erson who completed cause of death (Item 23a) (Typ	e, Print)	dell	Medical Conte		
Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 0 3 2005	books				

DH IAMES JOHN KOOLE, SR. 05-5313

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State of M. State Registrar	aryland / Depa <i>Cer</i>	irtment of He tificate of D		ientai Hyg Re	2005	27283	
	1		. Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death	
物	Physicia /Medic	al	James John Koole, Sr.				AUGUST	6, 2005	1638 Рм	
	Examin		a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL		4b. City, Town, or HAGERSTO			4c. County of Deal		
人	Funeral Director		253–88–6026 X□M 2□F	ge (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 16		hplace (State or Foreign ountry) Orgia	
	Maryland -f show	-	Jsual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits	
		ţ	Pennsylvania Franklin	Green	ncastle				1 ☐ Yes 2X No	
	r 28a	~ L	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Co	ountry?	
	th with	alD	13814 Williamsport Pike			7225		United Sta		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygiene. I Health and Menial Hygiene. Item 27 Is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exam. or must be notified at	by Fur		No 10 / 6 / 70	Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 XNo	spanic Origin? (Sp n, Mexican, Puerto Specify:			e, etc. White	
21215-0036	vithin 72 ho ne. han "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give	dent's Usual Occupa kind of work done o DO NOT use retired,	luring most of work)		16b. Kind of Business	,	
N	e filed within al Hygiene. i other than vent, the Me	ပ္	17. Father's Name (First, Middle, Last)		Dispatch	18. Mother's Name	e (First, Middle, I	Federal G Maiden Sumame)	overnment	
Maryland	Mental arked o	To Be	John Lewnis Koole			Ann Ma	e Perry	Koole		
ary	should be ind Mental marked umatic ev	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a	and Number or Run	al Route Number	, City or Town, State,	Zip Co de)	
	1 and 2 Health a iem 27 ls		Diane Marie Koole (wife)					eencastle,		
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Church Ce	natory of the fall	Aug 1	1, 05 douglas A	. Fiery Fu	ng Maryland	
	Physician		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each disease or condition	d the death. Do not ent line. Multiple in	er the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval 8etween Onset and Death	
	/Medical Examiner		Sequentially list conditions.	s a consequence of):						
	pet list	nine	cause. Enter Underlying Cause (Disease or injury	s a consequence oly.						
o,	ficate be executed physicien and s the burial-transit	Examine	that initiated events resulting in death) Last C. Due to (or a	s a consequence of):						
68760,	ate be hysici the bu	edical	d							
.O. Box 6	ath certil	Physician/Med		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year	
Δ.	quires that the de n signed by the a uld be detached	þ	Part II. Other significant conditions contributing to death	but not resulting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use contribute t es 2∰No 3□P	o the cause of death?	
of Vital Records,		Completed					24a. Was a autops perfor 1 Yes	sy prior to	utopsy findings available completion of cause of s 2 \sum No	
Vita	Attending Physician: Thir death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner? Hospital:		Oth	OF.	th (Check only or			
P	Phys r this ral dir	1: To	27. Manner of Death 28a. Date of In	ient 2 ER/Outpatier jury 28b. Time o	III SES DOA	4 Nursing H		ence 6 Other (Speow injury occurred	river in	
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Division	l or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be 28e. Place of I	njury - At home, farm, streetc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt. 40 Mers whe MO			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the besing and manner: and manner:	t of my knowledge, deat of examination and/or in	th occurred at the tin	ne, date and place, pinion, death occur	and due to the or rred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number	2	29d. Date signed (Mor	ith, Day, Year)	
			· famet fouthalf, no		OCI	ME	A	AUGUST 7, 2	2005	
Óh.	1-7+1		30. Name and address of person who completed cause of Particle E- Southell, MD	111 PENN		3ALTIMORE	, MARYLA	ND, 21201		
	St Regist	ate rar	8110	strar's Signature	neite					

DHMH 17 Rev 1/2001

ORIGINAL

	•	For State Registrar	State of Maryland / Dep Ce	partment of H		•	giene Reg. 12 .005	27284			
Physicia		Decedent's Name (First, Middle, Last) Sherman Rober				2. Date of De. Month	ath	3. Time of Death			
/Medica		4a. Fecility Name (If not institution, give s		4b. City, Town, o	r Location of Dea	108	4c. County of I				
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)	(If Under 1 Year	If Under 24 Hrs		Alleg	Birthplace State or Foreign			
Director		217-03-2036 ^{1X} Usual Residence of Decedent	M 2□F 86 Yrs.	Months Days	Hours Min	. (Month, Da	y, Year)	Maryland			
nyiand how		10a. State 10b. County	10c. City, Town or I					10d. Inside City Limits			
the Ma	ecto	Maryland Alleg	any Cumbe	rland			40 000	1 □ Yes 2 ☑ No			
deeth with the Maryland ms 23a or 28a-f show rmust be notified at	a Dir	11609 Poplar Av	e SW	2150	02		10g. Citizen of Wha	t Country?			
urs after ir, or ite	by Funeral Director	11. Marital Status 1 1 Never Married 2 Married 3 \(\frac{1}{2} \) Widowed 4 \(\Divorced \)	2. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give WW II Year or Dates:	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√2 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		American Indian, Vhite, etc. White			
within 72 hours atlene. ene. than "naturel; or	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. Dec (Giv life.	edent's Usual Occup re kind of work done o DO NOT use retired	ation during most of wo	orking	16b. Kind of Busin	Kind of Business/Industry			
d ZI		1 2 17. Father's Name (First, Middle, Last)	Ma:	ster Mec			Automot	ive			
E garage ■	To Be	Wesley Klipste				ne (First, Middle, na Craw)	Maiden Sumame) ford				
5 HEND		19a. Informant's Name/Relationship (Type Linda Phillips-	e, Print) Daughter 19b. Mai	ling Address (Street							
		20a. Method of Disposition	20b. Place of Disp	O. Box position (Name of ematory or other place		awlings Date	, MD 21 20c. Location - City	or Town, State			
Baltimore, permit. Peges 1 an Department of Heal Importent: if item 2 any injury or other		1 XBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	St. Amb	rose Cen	n. Aug	19,200	5 Cresa	otown,MD			
Department of the control of the con		2 Signature of Funeral Service License	110	Hafer Fu	meral	Service	, PA				
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_ @ O	e Co	25. Was case referred to medical			00 Blass - 4 Da		1	n? Yes 2□ No			
this all di	To B	examiner? 1 Yes 2 You	spital: 1 Inpatient 2 ER/Outpatie		er: 4 🗆 Nursing I		ne) ence 6 □Other (5	Specify)			
ION OT nding Phys th, t; After this s funeral di	ation:	27. Manner of Death 1 Alatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work	yat k? Yes 2 □ No	28d. Describe h	ow injury occurred				
To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	-0.02	28f. Location (S City or Tow	itreet and Number o n, State)	r Rural Route Number,			
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To the within To the	ē ⊠	29b. Signature and title of certifier	11	29c. License	e number		29d. Date signed (M				
0117		30. Name and address 1 person who cor	appleted cause of death (from 23a) /Type		2054		August	15,2005			
81, 1		DR CORPER DAVI	LLDSON 912 Set	on Drive	e Cumb	second	ind ai	205			
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		1. Decedent's Name (First, Middle, L	Item 24a per									
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/Medica		4a. Facility Name (If not institution, g			4b. City, Town, or Loca	ation of Death	August	4c. County				
Lxamme	31	Avalon Manor Hea		tor								
Funeral			Sex 7. Age (I	n yrs. last birthday) If Under 1 Year If U	Stown Inder 24 Hrs.	8. Date of Birth		Shington 9. Birthplace (State or Fore			
Director		577/46/8382	1□M 2ØF	71 Yrs.	Months Days Ho	ours Min.	October	Year) 933	Country) Arkansas			
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o se	5	Maryland Washin		Oc. City, Town or L					10d. Inside City Lim			
Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinational be notified at once.	by Funeral Director	10e. Street and Number	gcon		Hagers	town			1 🗆 Yes 2 🔀			
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atic	9	Marion Franklin				Lovie E	lvira B	rixeu				
S E E		19a. Informant's Name/Relationship		19b. Mail	ing Address (Street and No	umber or Rural	Route Number,	, City or Town, S	State, Zip Code)			
ealth m 27 her ti		Thomas M. Keely	<u> </u>	1451	11 Black Angu	us Road	Hagers	town, M	aryland 21742			
ite ite	- 1	20a. Method of Disposition 1 □ Burial 2 □ Communication 3	□Bemoval from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place)	Da	2005 2	20c. Location - 0	City or Town, State			
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ie = 0 ai	- 1	'4 Donation 5 Other (Specify) Smithsburg Crematory Aug. 12, Smithsburg, Maryla.										
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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EBU10

Hogerstown,

1126

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2005 **Physician** BETTY KNIGHT AUGUST 2 6:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDRICK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Virginia **Funeral** 1 □ M 2 X F Ĩ'937 Director 67 218-34-7200 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f show any injury or othar traumatic evant. Its Medical Examinations of the page 1. 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Dickerson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24210 River Road 20842 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ruby Hunt ೭ Robert Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Terry / Daughter 221 S. Jefferson Street Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State August 1 4 □ Donation 5 □ Other (Specify) 2005 Resthaven Mem. Gardens Frederick, Maryland 21. Signature o Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the tiseas shock, or heart fail 1. L Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line Immediate Cause (Final The **Physician** 0 disease or condition resulting in death) /Medical **Examiner** Secondaile Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed the attending physician and the for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disease olest west ve 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MD. D-54636 August 4, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Haque, M.D. 700 Montclair Avenue Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State AUG 0 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 8,2005 **Physician** 2:55 A M Louis Pierre Laborde /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 578-40-5811 74 Director September 21, 1930 Washington, Usual Residence of Decedent D.C. the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits itams 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with to and Mental Hygiene. Is marked other than "naturel", or Itams 23a or 2 U.S.A. 4027 Manheim Court 21755 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubag, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Tes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1□ Yes 2□ No Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Store owner Paint and Hardware store permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Louis Jean-Baptiste Laborde Marguerite Gardel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Laborde - wife 4027 Manheim Court, Jefferson, Maryland 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mary's Cemetery 8-12-2005 Petersville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) St. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home Eleve 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician intracranial hemorhage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (cr as a consequence of) The faw requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physiclen Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
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Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 7:30 Winter Lankford 2005 August 4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1021 Heron Court Salisbury Wicomico If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F 063-20-1814 Director 79 3/1/1926 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be nutified at 1X Yes 2 No Director Maryland Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural", or Items 23a 1021 Heron Court USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 1 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Ite Ma Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Blake Winter Sarah Brewster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Lankford/daughter 2235 California St.#2, Berkeley, CA 94703
De of Disposition (Name of Date 20c. Location - City or Tow 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 8/5/05 * 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metasteti 15 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or urjury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 20 1 Yes 200 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Hospital or Attending Pi 24 hours after death. Funeral Director: After to 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30690 Aus, 5, M, D. 30. Nam Ind address o Cerson who completed cause of death (Item 23a) (Type, Print) Jomes E Martin N.O. E. Casl1 57, 501.56007, MD 145 Pagistrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar Registrar's Signature

		For State	State of Ma		artment of Health and ertificate of Death			07001
		Registrar 1. Decedent's Name (First, Middle, La	st)		outo or Doutin	2. Date of Death		3. Time of Death
ysicia		Temple W.	Lord			August	12 20	05 9:10 AM
Medic: amine		4a. Facility Name (If not institution, gir			4b. City, Town, or Location of D	eath	4c. County of E	
		Genesis Health						lbot
eral ctor		218-34-8937	Sex 7. Age	73 Yrs.	If Under 1 Year	Min. 8. Date of Birth (Month, Day, May 12,	Year)	Birthplace (State or Foreig Country) Maryland
H		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
flied	tor	MD Caro	line		Preston			1 □ Yes 2¶ No
Total I	Director	10e. Street and Number			10f. Zip Code	10	g. Citizen of Wha	t Country?
4	ralD	6311 Harmony	Road		21655		Jnited :	
DE LE	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pr	? (Specify Yes or No- uerto Rican, etc.)		American Indian, White, etc.
Sami	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	MY Yes 2 □ N If Yes, Give Year or Dates:	° ¹ 50-53	1 ☐ Yes 2 🙀 No Specify:		Specify:	White
lical	eted	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. Dece	edent's Usual Occupation e kind of work done during most of	working 1	16b. Kind of Busin	ess/Industry
De Mes	Completed	Elementary/Secondary (0-12) 1 2	College (1-4or 5	+) life.	ck Driver		Trucki	ng
ent, I		17. Father's Name (First, Middle, Las	1)	1		Name (First, Middle, M	faiden Sumame)	
lic ev	To Be	Unknown			Netti	e Whitele	y Lord	Sulin
uma	٦,	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street and Number of	r Rural Route Number,	City or Town, Sta	ite, Zip Code)
2		Alice M. Loro	1/0	631	1 Harmony Roa	d Presto	on. MD	21655
9		HITCC II. HOTC	1/Spouse					
or other		20a. Method of Disposition		20b. Place of Diso	osition (Name of ematory or other place)	Date 2	20c. Location - Cit	y or Town, State
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Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To tha Funeral Director: A**fter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one) 29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)
§.17.05

cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
AUG 1 5 2005

32. Registrar's Signature South)

State Registrar

1		State of Maryland / Dep 1- State Unpend Item 23a,pt.II,27,28a-f			
Physic /Medi		1. Decedent's Name (First, Middle, Last) Edith R. Lehman	4b. City, Town, or Location of Death	2. Date of Death Month Day	3. Time of Death
Exami Funeral Director	A	4a. Facility Name (If not institution, give street and number) $\frac{106 \ \text{Carroll Drive}}{5. \ \text{Social Security Number}} = \begin{array}{c c} 6. \ \text{Sex} & 7. \ \text{Age (In yrs. last birthda} \\ 546-42-9278 & 1 \square \ \text{M} & 20 \end{array}$	Annapolis		ne Arundel
Maryland -f show iied al	tor	10a. State 10b. County 10c. City, Town or Maryland Anne Arundel	Location Annapolis	3	10d. Inside City Limits 1 ☐ Yes 2 ☑No
h with the 23s or 28s	al Director	10e. Street and Number 106 Carroll Drive	10f. Zip Code 21403	10g. Citi	izen of What Country? U。S。A。
If year to Z. I.Z. I.Z. I.Z. I.Z. I.Z. I.Z. I.Z.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
A I X I D-0000 ad within 72 hours af giene. er than "natural", or the Madical Exam	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of work b. DO NOT use retired) otocol Assistant	ing	ind of Business/Industry State of Maryland
be filed tal Hygi d other	To Be Co	17. Father's Name (First, Middle, Last) ### Rogers	18. Mother's Nam	e (First, Middle, Maiden e Baggett	
M 2 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Joel Lehman/husband 100	the state of the s	napolis, Ma	ryland 21403
Daltimore, permit. Pages 1 er Department of Hea Important: If item any injury or otha		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemetery, c Lakemont	rematory or other place) t Mem. Gardens 8/9	/2005 Dav	ridsonville, MD
Departing Permit			22. Name and Address of Facility JC	ter St., An	
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HECONGS, P.O. BOX 08/ The law requires that the death certificate the has been signed by the attending physpage 2 should be detached for use es the	Physician/Medi		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
COLGS, P. w requires that the second of the	þ	Part II. Other significant conditions contributing to death but not resulting in the Hypertensive Atherosclerotic Cardiov		23e. Did tobacco u 1 ☐ Yes 2	use contribute to the cause of death?
The law recented has bee page 2 shot	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 \(\subseteq \text{No} \)
Division of Vital Records, To the Hospitel or Attending Physician: The law requires! within 24 hours effer death. To the Funeral Director: Affer this certificete has been signs completely filled in by the funeral director, page 2 should be	To Be	25. Was case referred to medical examiner? 15 Yes 2 No 27. Manner of Death 1 Natural 2 Accident Service and investigation investigation of Yes (Month, Day Year) 28b. Time (Month, Day Year) Found 8-1-05	tient 3 DOA Cther: 4 Nursing H	th (Check only one) ome 5 Residence 28d. Describe how inju	ry occurred unk
DIVIS tel or Atte rs efter de al Directe ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6		28f. Location (Street ar City or Town, State Annapolis,	nd Number of Rural Route Number) 106 Carroll Drive Md
To the Hospitel within 24 hours e To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do and manner stated.	r investigation, in my opinion, death occu	rred at the time, date and	d place, and due to the cause(s)
To with To con	2	29b. Signature and title of certifier California AR "	29c. License number OCME		nst 2, 2005
		30. Name and address of person who completed cause of death (Item 23a) (Ty	111 Penn Street,	Baltimore,	Maryland 21201
S Regis	tate trar	31. Date filed (Month, Day, Year) AUG 0 4 2005 32 Registrar's Signature	books		

ORIGINAL

			1 - For State Registrar	tate of Maryland / Depa	artment of Health and Martificate of Death		0005 05000
	Physici	an	Hegistrar 1. Decedent's Name (First, Middle, Last) Dennis Mark M		incate of Death	2. Date of Death	3. Time of Death
1	/Medic Examir	cal	4a. Facility Name (If not institution, give stree	t and number)	4b. City, Town, or Location of Death	HUGUST	7 3005 17 10 M 4c. County of Death
	Funeral		Washington Count 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Hagerstown, If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Washington 9. Birthplace (State or Foreign Country)
	Director		219-52-2132 X □ M Usual Residence of Decedent			8. Date of Birth (Month, Day, Ye Feb 18, 1	
	a-f show	ctor	MD 10b. County Washingt	on 10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2√2 No
	h with the	Funeral Director	10e. Street and Number 11916 Cove Road		10f. Zip Code 21722	10g.	Citizen of What Country?
036	urs after deal al', or Itams :	by	A	☐Yes 2√☐No	Nas Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race - American Indian, Black, White, etc. White Specify:
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic evant. Its Medical Exam art must be multipliated an once.	Completed	4 4		lent's Usual Occupation kind of work done during most of work DO NOT use retired) ES director	ing Ha	Kind of Business/Industry
yland ;	ould be filed Mental Hyg arkad othe atic evant,	To Be C	17. Father's Name (First, Middle, Last) Andrew Michael	,	Edna	e (First, Middle, Maid Martin	
	and 2 sho raith and n 27 is m er traum		19a. Informant's Name/Relationship (<i>Type</i> , F Jo Anne Michael		g Address (Street and Number or Rui 16 Cove Rd.Clea		
altimore,	Pages 1, nent of He ant: If itan ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place) Aug. I		Location - City or Town, State Clear Spring, MD
Balt	permit. Departr Importu any injo		21. Signature of Funeral Service Licensee	Zini P.	Name and Address of Facility Onald Edwin Tho	mpson Fu	neral Home, Inc ,MD 21722
1	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, reducing to immediate cause. Enter Underlying Cause (Disease or injury	ons that gaused the death. Do not ente	er the mode of dying, such as cardiac Cardi ovascular	or respiratory arrest,	Approximate Interval Batween Onset and Death
8760,	cate be executed obysician and the burial-transit	Ilcal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
.O. Box 6	death certifii a attending p d for use as	Physician/Medical	in the past 12 menths?		Ectopic pregnancy Other (specify)		. 23d. Date of delivery Month Day Year
rds, P.	quires that n signed b	by	Part II. Other significant conditions contribu	ting to death but not resulting in the un	derlying cause given in Part I.		o use contribute to the cause of death? 2 12/10 3 12 Probably 4 12 Unknown
Vital Records,	The law requires that the sate has been signed by the page 2 should be detached.	Completed	/			24a. Was an autopsy performed?	
V VIE	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	tal: 1 ☐ Inpatient 2 🖼 ER/Outpatient		h (Check only one)	6 ∏Other (Specify)
Division of	nding Ph ath. r: After th e funeral		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	Ba. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in	
DIVIS	Hospital or Attending Physician: 44 hours after death. Funatel Director: After this certificately filled in by the funeral director, tely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28	 Place of Injury - At home, farm, stre building, etc. (Specify) 	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital within 24 hours a To tha Funarel completely filled	edical ((Check only 2 Medical Examiner: (n: To the best of my knowledge, death On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
)	To the Ho within 24 t To tha Fu completely	Me	29b. Signature and title of certifier R. L. Kysker	2/6/	29c. License number		Date signed (Month, Day, Year) 8/9/2005
H	15	1,	30. Name and address of person who comple	ited cause of death (Item 23a) (Type, F	DOOZESTS THERN AVE,	IAGENSTA	MANYLAND
	Sta	te	31. Date filed (Month, Day, Year)	32. Prigistrar's Signature	and	, , , , , , , , , , , , , , , , , , , ,	11.731.00

State of Maryland / Department of Health and Mental Hygiene

					C	ertificate of	Death	Re	g. No? () (15	27294
	Dharaia		1. Decedent's Name (First, Middle, Las	t)			2	Date of Death	h Dey	Year	3. Time of Death
d.	Physic /Medi		GRACE	M	ICHAEL			ugust	7,200	5	4:05 PM
, ,	Exami		4a Facility Neme (If not institution, give			1	4b. City, Town, or Loca	tion oi Death	4c. County	of Death	
			Williamsport			M Haday 1 Voor	Williams	sport	Wa	shin	gton
	Funeral Director		230-14-0332	7. Age (In	yrs. last birthda 1 Yrs.	Months Days	If Under 24 Hrs. 8 Hours Min.	(Month, Day,	Year)	9. Birthp Cour 4 We	place (State or Foreign stry) st Virgin
	and *		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or	Location				1	0d. Inside City Limits
	Many ¹	ō		acton	Willia	msport					1 Yes 2 □ No
	the 1	9	Maryland Washir 10e. Street and Number	igcon		10f. Zip Code		10	Og. Citizen oi V	Vhat Cour	ntry?
	Sa o	ō	154 North Artiz	zan Street		2179	95		U.S	Α.	
	death	Jera	11. Marital Status	12. Was Decedent Ever Armed Forces?			lispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No-	14. Rac	e - Americ	can Indian,
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show mit hours or other traumetic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces; 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No		can, etc.)	Specify	k, White, Wh	etc. nite
5-0	72 ho	ited	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Dec	cedent's Usual Occup ve kind of work done	pation during most of working	1	16b. Kind of Bu	siness/In	dustry
21	within ene.	현	Elementary/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT use retire	d)		_		
	filed w Hygier offher th	ပ္ပ		1	S	Secretary					Company
and	d of H	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (F				
2	should be and Mantal I marked of umatic eve	우	Elmer		ichael		Rachel and Number or Rural F		ginia		Godlove
Maryland	12 sho h end I r is me traume		19a. Informant's Name/Relationship (T)								
	1 and Health em 27		Charlene K. Llo 20a. Method of Disposition	oyd Frien	Ob. Place oi Dis	position (Name of	are, Hagers	Stown,	Marylar 20c. Location -	nd 21	740 wn. State
Baltimore,	nt of in the correction of the		1X Burial 2 ☐ Cremation 3 ☐ I	Removal irom State	cemetery, cr	rematory or other pla	ce)			•	
Ħ	Demit. Pages Department of Important: If It any injury or o		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens			lle Cemet		-10-05	Wardens	svill	e, W. Va.
Ba	permit. Departr Imports any inju	8	R hall	0 /			Coffman Fur tietam Stre	eral H	ome. In	10.	
_			10.100	000	4	10 East An	tietam Stre	et, Ha	gersto	vn, M	d. 21740
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne ca e on each line.	death. Do not e	anter the mode of dys	ng, such as cardiac of h	espiratory arre	15 1,		Approximate Intervel Between Onset and Death
A	Physician /Medical		Immediate Cause (Final	A	(-D -	- 73 A.					
	Examiner		disease or condition resulting in deeth)	. HOUTE		IBRAL :	INFARCT				1 WEEK
	•	ē			to (or es a cons		3 Dicci	NCE		1	8 YEARS
	uted d ansit	Medical Examiner	Convention to that conditions	b. CEREBR	to (or as a cons	ASCLUAT	2 BUSE	4>0			O TOTICS
Ó,	The law requires that the death certificate be axecuted at a has been signed by the ettending physician end page 2 should be detached for use es the bunet-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		10 (01 40 4 90110	3,7					
68760,	te be ysicia ne bu	Ca	triat initiated events	c	to (or as a cons	equence of):					
	rtifica ng ph es th	8	resulting in death) Last							1	
Box	th cer endir r use			d							
	dea he ett	Physician/	Part II. Other significant conditions co	ntributing to death but no	t resulting in the	underlying cause give	ven in Part I.	23b. Did tol	bacco use co	ntribute to	the cause of death?
P.0	at the d by ti etach	Ph						1 □ Ye	s 2K No	3 ☐ Prof	bably 4 Unknown
	v requires that the death cert been signed by the ettendin should be detached for use	by					······				
Records,	een s	Completed						24a. Was er perform	n autopsy ned?	ava	ere autopsy findings ailable prior to mpletion of cause
e	elawi hasb ge2st	ם								of	death?
F								1∐Ye	5 2 2 thu	1[]Yes 2□No
Vita	ician: The certificata rector, pag	B	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Death (C				
of Vital	Physician: rthis certific rel director,	은	1 Yes 25 No 27. Menner of Death	1 ☐ Inpatient	2 ER/Outpati	ient 3LI DOA	42 Nursing Home		nce 6 □Oth w injury occuri		v)
ü	tending Ph leath. tor: After th tha funerel	5	1 Natural 5 ☐ Pending	(Month, Dey Yea	ar) Injury	/ Wo	rk? Yes 2□No	a. Describe no	w injury occur	00	
Division	f or Attending after death. Director: Atte	Certification:	3 Suicide 6 Could not be	28e Place of Injury	At home, farm,			. Location (Str	reet end Numb	er or Rura	il Route Number,
<u>></u>	or A after Direction by	er#	4 Homicide determined	28e. Place of Injury - building, etc. (S)	pecify)	on con, raciony, critico		City or Town	, State)		
_	ppital ours ours herai		29a. Certifier 12 Certifying Phy	eicien: To the best of my	knowledge, de	eth occurred at the tis	me, date end place, and	d due to the ca	use(s) and ma	nner as si	teted.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atter completely filled in by the fune.	edicai	(Check only 2 Medical Exami	iner: On the basis of exa- end manner stated.	mination and/or	investigation, in my o	ppinion, death occurred	at the time, da	ite and place,	and due to	the cause(s)
_	Withir To the	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signe	(Month,	Day, Year)
			* TRAIQUE.	M		137	3700	1	Jugus-	9	2005
			30. Name and address of person whele	ompleted cause oi death	(Item 23a) (Type				1407		
1-1	-3		TED E. HOWE	154 N.	ARTIZA	N 87.	WILLIAMSF	PORT, r	ND	717	95
2	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S		,					
	Registi	ar	AUG 10 20	05	K A	Carlo					

DHMH 16 Rev 6/95

			For	State of Maryland / Department	of Health and Me	ental Hygie	ne	
			1 - State Registrar	Certificate	of Death	Reg.	manns 27205	
	Physic	ian	Decedent's Name (First, Middle, Lass			2. Date of Death	3. Time of Death	1
	/Medi		Kuth Ker	inedy Moore		Month	7 2005 7:45 A	М
	Exami	ner	4a. Facility Name (If not institution, give	street and number) 4b. City, T	own, or Location of Death		4c. County of Death	
7			5. Social Security Number 6. Se	ills (or	Marilla		Queen Anne	
п	Funeral Director				Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Fore Country) Malyland	ign
4			Usual Residence of Decedent	73		2/3/19	10 Maeyland	_
	rylan how		10a. State 10b. County	10c. City, Town or Location			10d. Inside City Lim	its
	e Ma	cto	MD Queen	Anna Centrevilla			Yes 2□	No
	with the Maryland ta or 28a-f show	Dire	10e. Street and Number	10f. Zip (Code		Citizen of What Country?	
	death v	rai		ille Road 21	617		AZ	
	ter de	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes No	ent of Hispanic Origin? (Spec fy Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	 Race - American Indian, Black, White, etc. 	
920	hours after tural', or Ite	by	3X Widowed 4 □ Divorced	If Yes, Give 1 Yes 2	No Specify:		Specify: Black	
5-0036	72 ho	Completed	15. Decedent's Ed	cation 16a. Decedent's Usual	Occupation	16b.	. Kind of Business/Industry	
21	within 7 ene. then "r he Med	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-401 5+)	done during most of working retired)			
121	filed with Hygiene. Ither ther	Cor	124h	Domesti		AC	dult Caregivel	حر
and	ould be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, Last)	1/	18. Mother's Name (First, Middle, Maid	len Sumame)	
Maryland	hould d Men marke matic	5	JEREMIAh 19a. Informant's Name/Relationship (T	Kennedy 10h Maille Address	MUDIC	C. W	ILSON	
Z	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hyglene. It has the marked other then "natural", or Items 23a or 28a-f show tiem 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner instead or routified at		1/		0-	Ω1 -	y or Town, State, Zip Code) 2064	O.
ē,	Hea Hea tem		20a. Method of Disposition	20b. Place of Disposition /Name	of Dat	1 -	Location - City or Town, State	<u>د</u>
e E	0 0		1 Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,		er leed ge	1.		
Baltimore	pernit. Pag Deportment Important: I any njury o		21. Signature of Funeral Service Licens		Address of Facility	191000	entreville, MD	_
Ö	Deparement of the control of the con	1	Mammie	Show Benni	ie Smith F	H. Was	HON, MD 21678	2
			23a. Parti. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the death. Do not enter the mode	of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	congestive heart	filure		Onset and Death	
4	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	Jacob C		MOUNT	
	LAGITILIEI	<u>.</u>	Sequentially list conditions,	arial fibrillation			(MALLON)	
	pei lisit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
_	xecul and al-trar	xan	that initiated events resulting in death) Last	Due to (of as a consequence of):			years	
68760,	icate be executed physician and s the burial-transit	alE		chanic obsmich	ve pulmunas	dilens	0 11/2015	
.89		edical			o e populario	(Micas	e years	
Вох	n cert	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pred			23d. Date of delivery	
	deat	sicia	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic prec 4 ☐ Pregnant at time of death 5 ☐ Other (spec 9 ☐ Unknown			Month Day Year	
P.0	that the de led by the a detached	Phy	9 Unknown					
	eg pe	by	Part II. Other significant conditions co	tributing to death but not resulting in the underlying cau	se given in Part I.		use contribute to the cause of death?	
Vital Records,	w requir been s should	Completed				1 Tes	2 No 3 Probably 4 Unknow	'n
3ec	has b	nple				24a. Was an autopsy	24b. Were autopsy findings availab prior to completion of cause of	le
<u>e</u>	Ø □					performed? 1□ Yes 2☑ N		
Σ		o Be	25. Was case referred to medical examiner?	lospital:	26. Place of Death (C			
o	Physer this seal di	H	1 Yes 2 No	1 Inpatient 2 EH/Outpatient 3 DOA	ursing Home	5 Residence Describe how inj	6 Other (Specify)	
ion	Attending I or death. ector: After by the funer	atlo	1. ■Natural 5 Pending 2 Accident investigation	(Month, Ďaý Year) Injury M	c. Injury at 280 Work? 1 ☐ Yes 2 ☐ No		12.7	
Division	Attendi er death. rector: A by the fu	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	office 28f	. Location (Street a	and Number or Rural Route Number,	-
Ö	tel or rs afte al Dir	Certification;	Tiomodo	building, etc. (Specify)		City or Town, Sta	(e)	
	To the Hospitel or Attenwithin 24 hours after deating the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knowledge, death occurred at her: On the basis of examination and/or investigation, in	the time, date and place, and	d due to the cause(s) and manner as stated.	_
	the hin 2 the fundamental the	Med		and mariner stated.				
	To To		29b. Signature and aftle of certifier	1/21/	icense number	29d. D	ate signed (Month, Day, Year)	
			30 Name and address of	your Do	11621	18	-11-05	
				mpleted cause of death (Item 23a) (Type, Print) v, 2540 Centreville Road,	Centrovillo	MD 2161	7	
	Sta	te	31. Date filed (Month, Day, Year)	32. Resistrar's Signature	Jenereville,	110 ZIUI	. 1	
	Domina	a é	AHC 1 1 2	105				

			1 - For State Registrar	icusc				Depar	tment of F	lealth a		ntal Hy		iegibii	2	720	36
	*	31	Decedent's Name (First)	Middle, Las	it)						2	. Date of Dea	ath			3. Time of	Death
	Physici /Medi		Mary Doi	cothy	Murdock						A	Month August	Day 4	20°	05	11:58	Рм
	Examir		4a. Facility Name (If not in						b. City, Town, o	Location of	_		4c. C	county of [Death		
			St. Mary's H	Hospit	al				Leonar	dtown			St	. Ma	ry's	3	
	Funeral		5. Social Security Number		ex □M 2ÅF	7. Age	(In yrs. last b		If Under 1 Year Months Days	If Under 2 Hours	Min. 8	. Date of Birti (Month, Day	h			ice (State o	r Foreign
	Director		577-40-3522		M 2431F		74	Yrs.				ovember	21,19	30 Dis	stric	t of C	olumbi
	and		Usual Residence of Deced	County			IOc. City, To	wn or Loca	tion						100	d. Inside Ci	tv Limits
	Maryl f sho	0	M1 G.													1 🗆 Yes	1
	the /	Director	Maryland St 10e. Street and Number	. Mary'	S		Lexing	ton Pa	10f. Zip Code		-		10g. Citize	en of Wha	t Countr	v?	
	3s. or	Ö	21756 Saratoga	Drivo					20653				USA			,	
	filed within 72 hours after death with the Maryland Hygiene. uther then "neturel", or Items 23s. or 28s-f show ent, the Medical Exam scrinust by notified at	Funeral	11. Marital Status	DIIVE	12. Was Dece	edent Ev	er in U.S.	13. Wa	s Decedent of H	ispanic Orig	in? (Speci	fy Yes or No-		Race - A			
9	after or Ite		1 Never Married 2	X Married	Armed Fo 1 ☐ Yes	2 X No		1	es, specify Cuba ∃Yes 2⊠ No		, Puerto Hi	can, etc.)		Black, V	Vhite, et	tc.	
93	rel',	d by	3 Widowed 4 Di	vorced	II Yes, Giv Year or D	ates:		11.	Tres ZELINO	эреспу:				pecify:	White	e	
5-0	72 h netu	Completed		cedent's Ed	ucation de completed)		16	a. Deceder (Give kir	nt's Usual Occup nd of work done of NOT use retired	ation during most	of working		16b. Kind	of Busin	ess/Indu	ıstry	
2	vithin ne. hen	mpl	Elementary/Secondary (0-12)	College (1	I-4or 5+)				0							
2	iled v Hygie her t	ပိ	12 17. Father's Name (First, M	Aiddle (act)				Cook		10 Mothor	do Noma (First, Middle.		Gover	nment		_
anc	l be fintal hed of	Be									,			umame)			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23s or 28a-1 show eny injury or other treumetic event, the Martical Examera must be notified at once.	To	Theodore Burni 19a. Informant's Name/Re				10	h Mailing	Address (Street			s Fernai		Tour Sta	to Tip C	Po do l	
Z a	d 2 s th an treu															,	
စ်	1 an Heal Iem 2		Larry Michael 20a. Method of Disposition		/ Husbar	10	20b. Place	of Disposit	Saratora l ion <i>(Name of</i>		Lexing Dat		_	yland ation - City			
آ و	Pages nent of int: If It iry or o		1 X Burial 2 ☐ Crem 14 ☐ Donation 5 ☐ O			State			eart of other place		August						,
量	artme orten injur	1	21. Signature of Funeral S			,	Mary C	22. N	ame and Addre	s of Facility	9, 200				ark,	Maryla:	nd
Ba	permit Departr Import eny inj		Taishan	19800	Tai Ola	Men	· Jak	Mat	tingley-Ga . Box 270	ardiner	Funer	al Home	P.A.	650			
			23a. Part1. Enter the dise shock, or heart failur	ase, or comp	olications that c	aused th	ne death. Do	not enter	the mode of dyin	g, such as c	ardiac or r	espiratory ari	rest,	050	1	Approximate nterval Bety	3
	Pnysician		Immediate Cause (Final	e. List only	one cause on e	acri line.	ation	^	Preum gived	onitio					li C	nterval Bety Onset and D	veen)eath
	/Medical		disease or condition resulting in death)	-	a Due to	or as a	consequence	e of):		0					+		
	Examiner				Come	mun	h	Acau	gred	11	euv	mil	ñ				
8		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e J	Due to (orasa	conrequence	9 OT):									
	ate be executed hysician and he burial-transit	Examiner	that initiated events		C		nuon								10		
760,	e exe ian a urial-i		resulting in death) Last	- 1	Due to (or as a	consequence	∋ of):									
976	ate bu hysic the bu	Ilcal		•	d												
89 >	ires that the death certifica signed by the attending ph d be detached for use as th	hysician/Med	IF FEMALE:												1		
Вох	ath c	lan/	23b. Was decedent pregn in the past 12 months	ant j		irth 2	Fetal déal		ctopic pregnancy				23	d. Date of Month			'ear
o.	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4∐Pregn 9∐Unkno		ne of death	5 ∐ C	ther (specify)							_, .	
	The law requires that the te has been signed by th age 2 should be detache	Φ.	Part II. Other significant of	onditions co	ontributing to de	eath but	not resultina	in the unde	arlving cause give	en in Part I		23e. Did to	bacco use	contribut	e to the	cause of de	eath?
MURDOCK Records,	sign d be	d by	OM						, , ,							oly 4 0 0	_
	w require been si should I	lete	Arenjo	 1								24a, Wasa		24h War	a autono	y findings a	uniahlo.
MURDOCK Records,	nysicien : The law his certificate has I I director, page 2 s	ompleted	1 1 0000								_	autops perfor	sy med?	prior deatl	to comp h?	oletion of ca	use of
HY tal		Ö	25. Was case referred to r	nedical						OS Place	of Dooth //		2 L NO	1 🗆 `	Yes 2	No	
OTHY Vital	Physicien: this certific ral director,	Ö.	examiner?	-	Hospital:	n patient	2 🗆 ER/C	Outnationt	3C DOA Othe			Check only or 5 ☐ Resid		7Othor (6	Tanaif I		
DOROTHY n of Vital	g Phys er this eral di		27. Manner of Death		28a. Date of			Time of	28c. Injun	at	7	d. Describe h			эр ө спу)		
You	ath. r: Aft	atlo		Pending investigation		II, Day I	ear)	Injury	M 1 🗆	r Yes 2∐N	lo						
MARY D	or Attending after death. Director: After in by the fune	tific		Could not be determined	286. Place	of Injury	- At home, (Specify)	farm, street	, factory, office		28f	Location (S. City or Town	treet and i	Number o	r Rural F	Route Numb	oer,
Σ ä	tal or rs aft ral Di	Certification:			5411511								n, otato,				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 M	ertifying Phy edical Exam	sician: To the	best of	my knowledo xamination a	ge, death o	ccurred at the time stigation, in my op	e, date and	place, and	due to the c	ause(s) ar	nd manne	r as state	ed. ne cause(s)	
	the hin 24 the 5	Med	Olie)		and mann	ner state	d.				1 00001100						
	To With		29b. Signature and title of	certifier	le -		Y00		29c. License	_	27	2	29d. Date :				
	No.	1					/			50	LT		0	-5	- 5	/	
(21/1		30. Name and address of MANOJ D. PANW	1			th (Item 23a)		,	RLOTT	E HAL	L,MD.	2062	2			
	Sta	ite :	31. Date filed (Month, Day	Year)	32. R	egistr#	s Signature					-					
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			For Amend#31,]	per DVR, 8-	arylan 10-0	d/Depa	artmen dificate	t of H	ealth a	and M	lental Hyg	jiene	05	27207	
	Physical		1. Decedent's Name (First, Middle,								2. Date of Dea Month		Yeer	3. Time of Beath	
	Physici: /Medic	al l		aughlin							Augus	+ 4	200		л —
	Examin	er	4a. Facility Name (If not institution,			1 -	4b. City,	Town, or	Location	_		4c. Coi	unty of Deat	n -	
			University of Mary			last birthday)	If Under	1 Year	If Under		8. Date of Birth		9 Birt	hplace (State or Foreign	מר
	Funeral Director		5. Social Security Number 180 24 1714	1 M 2 GyF	74	Yrs.	Months	Days	Hours	Min.	Jan 9,	1931	Pe	nnsylvania	
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	ylanc	. [10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 No	
	Mar 6-1-8	ctor	DE New C	astle	В	ear)
	or 28	Director	10e. Street and Number				10f. Zip					•	of What Co		
	ath w	ral	219 Gladstone W					1970			7 V N		ted S	tates irican Indian,	_
	er de items	Funeral	11. Marital Status	12. Was Decedent Armed Forces 1 Tyes 2 5	?	1.5.	If Yes, spec	ent of Hi	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)	14.	Black, White		
36	rs aft	by	1 ☐ Never Married 2 ☐ Marrie 3 🕱 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	_		1 🗌 Yes	2 No	Specify:			Spe	ecify: W	hite	
21215-0036	72 hours after death with the Maryland natural', or Items 23s or 28e-f show disal Evaninat must be modified at		15. Decedent	Education		16a. Dece	dent's Usua kind of wo	al Occupa	ation	t of work	ina	16b. Kind o	of Business/	Industry	_
215	within 7 ene. than "n	pje	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	5+)	life.	DO NOT us	e retired)	i oi woin	,,,,,		7. 7		
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Maryland	d la b y	Be	17. Father's Name (First, Middle, L								e (First, Middle, cy Haqqe		name)		
Z		ဥ	Joseph Koska Cl			10b Maili	na Addross	Į			al Route Numbe		um State	Zin Codel	
Mai	d 2 sho th and 7 is ma treum		19a. Informant's Name/Relationsh								Licott C				
	s 1 and 2 should if Heelth and Mer item 27 is marke other treumatic		Stephen R. McLa 20a. Method of Disposition	nduttu/2011	20b. F	Place of Dispo	sition (Nan	ne of			Date			Town, State	_
nor	00		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		9	cem <i>etery, cre</i> John				8-9.	-2005	Ellic	ott C	ity, MD	
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ñ	permit. Departr Importe any inj		Aun Ollis	white	1101	4	112 0	ld C	olumb	oia 1	Pike E11	icott	City	, MD 21043	Ī
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cause	d the deal									Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	M	o car	dial	In	fort	101					Onset and Death	
	/Medical		resulting in death)	Due to (or a	s a consec			1 1						11)	_
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	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	c. <u>Sev</u>	s a consec		In hou		11C	(CCO :	15			1 day	_
8760,	be ey ician buria					,									
687	ficate phys s the	edicai		d											_
Вох	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			75					23d.	Date of del	ivery	
	death e ette d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant			Ectopic pr Other (sp						Month	Day Year	
P.0	at the de by the	hys	9 Unknow	9Ll Unknown											_
	es that igned b	by F	Part II. Other significant condition	s contributing to death	but not res	sulting in the u	ınderlying c	ause give	en in Part I	l.				the cause of death?	_
ord	w require been si should l										1 U Y	es 2 N	o 3 Pr	obably 4 Unknown	1
e C	e law r has be	Completed							_		24a. Was a autop	SV	prior to d	itopsy findings available completion of cause of	Θ
<u>=</u>		Cou									perfor	2 No	death?	2 X No	
Vital Records,	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Othe	ar _		h (Check only or			·	
of	Phys this ral dii	. To	1 Yes 2 No 27. Manper of Death	28a. Date of In		ER/Outpatie		DA	4 🗆 NI	ursing Ho	me 5 Resid			;ify)	
	ding h. h. After funer	tion	1 Natural 5 Pending 2 Accident investig	(Month, D	ay Year)	Injury	М	8c. Injury Work	<br Yes 2 □	No					
Division	or Attending after death. Director: After din by the fune	fica	3 Suicide 6 Could no	ot be 28e. Place of I	njury - At h	ome, farm, st	reet, factory	, office					umber or Ru	ural Route Number,	_
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	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by			Physicien: To the bes											
	To the H within 24 To the Fi complete	ledical	one)	and manner		ation and/or in					at the time, c				_
/	2 4 5 6	Σ	29b. Signature and title of certifier	MD			290	. License		014	2	Jan Jan Si	gned (Mgntl	7/05	
1	9)				4	- 00 \ =	D4:::		10	- (1 /:	1 - 1	1	
-	86		Paola Pill	no completed cause of	death (Iter	m 23a) (Type, Un) √. (ary	lon	e 1	reduct	' Cli	ten	2420142	
	s Sta	ite	31. Date filed (Month, Day, Year)	2005 32. Figis	trar's Signa	ature		0			l.	,	. /	4	_
	Registr	ar	08/0 M/09 8	2003		N /		AUG	08	2005	Deser	U St.	Gos	We	_

			_ FOI	artment of Health and Ment crtificate of Death	al Hygiene Reg 2005 27298
	Physicia	an	1. Decedent's Name (First, Middle, Last) Melvin W. Murphy		ate of Death onth Day 2005 3. Time of Death \$\mathcal{O} \text{O}
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	F		105 Charlotte Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Federalsburg If Under 1 Year If Under 24 Hrs. 8. Da	Caroline ate of Birth 9. Birthplace (State or Foreign
	Funeral Director		216-44-8488 ¹ ⅓ ^{M 2□ F} 59 Yrs.	Months Days Hours Min. (M	9. Birthplace (State or Foreign Country) 0/18/45 Maryland
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L		10d. Inside City Limits
	he Mar 88e-f si	Director		ederalsburg	10g. Citizen of What Country?
	h with t	ai Dir	106. Street and Number 105 Charlotte Avenue	10f. Zip Code 21632	United States
036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It amd Mental Hygiene. It is marked other then "naturel", or Items 23e or 28e-f show treumatic event, I've Medical Examinal must be multiped at	by Funerai	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Mes 2 □ No If Yes, Give 1968 - 70	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 🛣 No Specify:	res or No- , etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	filed within 72 ho Hygiene other then "natur ent, the Medical	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation be kind of work done during most of working DO NOT use retired) Chouseman	16b. Kind of Business/Industry Feed Mill/ Lumber Yard
yland 2	should be filed and Mental Hygis marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Melvin H. Murphy	Gladys P	
Mar	and 2 sho ealth and n 27 Is ma			ing Address (Street and Number or Rural Route Charlotte Ave.,	te Number, City or Town, State, Zip Code) Federalsburg, MD 21632
Baltimore,	Pages 1 nent of Hi snt: If iter ury or oth		Hill Cr	est Cemetery 8/7/	
Balt	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Licensee	^{12. Name and Address of Facility} Framp 16 N. Main St., Feder	tom Funeral Home, P.A.
	rnysician /Medical Examiner	iner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b. Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury)	hic lateral sc	Interval Between
68760,	death certificate be executed e attending physician and od for use as the burial-transit	dicai Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of): d.		
O. Box	at the death certifica by the attending platached for use as t	Physician/Med		□Ectopic pregnancy □ Other (<i>specify</i>)	23d. Date of delivery Month Day Year
S, P	res that igned to be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	and and and and and and and and and and	3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown
Record	The law requires that the sate has been signed by the page 2 should be detache	Completed	Coronary array acses	2-	14a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
Vital		Be Co	25. Was case referred to medical examiner?	26. Place of Death (Che	
of	Phys	ပ္	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 No Shural 28a. Date of Injury (Month, Day Year) Injury		5 Residence 6 □ Other (Specify) Describe how injury occurred
sion	ttending F death. ctor: After y the funera	ation	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division	el or Attus safter de l Directo d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		ocation (Street and Number or Rural Route Number, ity or Town, State)
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medicai C	29a. Certifier (Check only one) Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at t	the time, date and place, and due to the cause(s)
)	with To	2	29b. Signature and title of certifier A A A A A A A A A A A A A	29c. License number 0047534	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type 9 20 Market St. Denton	Print) 40 2/629	
	Sta Registr	rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ack!	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2005 August 6, 3:45 p. Carrie Mae NELSON /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) **Examiner** Holly Place North, 240 S. Potomac St. Washington Hagerstown If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🕃 F Yrs 94 28, 1910 Pennsylvania Director 171-03-8766 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State or 28e-f show e filed within 72 hours after death with the Maryla at Hygiene.
other then "naturel", or ttems 23s or 28e-1 show vent, Its Medical Examiner must be notified at 1K Yes 2 No Directo Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Holly Place North, 240 S. Potomac St. 21740 USA Compieted by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify. white 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) food waitress 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Mental H tent: If Item 27 is marked off jury or other traumatic even Be Ida Agnes Fritz William Henry Lehr 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 64 Old National Pike, Hagerstown, Maryland 21740 Anne Cox - friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Cedar Lawn Mem. Park 8/10/05 Hagerstown, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee red L. Vesta 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KILUNC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 1No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed? page certificate 1 ☐ Yes 2 1 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Warrsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Delatural 5 Pending 1 ☐ Yes 2 ☐ No М investigation death. neral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0041131 U4.D. TEPPY COPPECE 30. Name and address of person who completed cause oldeath (Item 23a) (Type, Print)

3H-0

State Registrar 31. Date filed (Month,

DHMH 17 Rev 1/2001

ORIGINAL

Gagerstown

Court

32. Registrar's Signature

Parl

			For State Registrar	State of	Maryland / Do	epartment of I Dertificate of		,	giene	15	27300
			Decedent's Name (First, Middle	le, Last)				2. Date of Dea	ath		3. Time of Death
	Physici		Dorothy	Grace	Nelsor			Month August	8, 2	_{Үөаг}	3:15 p.m. ^M
	/Medio Examir		4a. Facility Name (If not institution				or Location of Dea			ity of Deat	
П			Waldorf H	ealthcare			Waldorf		C	har1e	es
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. last birth	Months Days	If Under 24 Hr Hours Mir		h v Year)	9. Birt	thplace (State or Foreign
	Director		102-03-4240	TOM 200F	85 Yr	s. Days	THOUSE MAIN	Oct. 2,			nington, DC
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location	7				10d. Inside City Limits
	dary!	ō	V 1 1 G							i	1 ☐ Yes 2 No
	286-	Directo	Maryland St	. Mary's		HC 10f. Zip Code	11ywood		10g. Citizen o	f What Co	unto/2
	3e or		43109 Coles Di	ritto			636		_		•
	death ms 2:	Funerai	11. Marital Status	12. Was Deced	lent Ever in U.S.	13. Was Decedent of I	Hispanic Origin? (Specify Yes or No-	United		rican Indian,
ထ	or ite	Fur	1 ☐ Never Married 2 ☐ Mar	ried 1 Yes 2	2 € No	If Yes, specify Cub		irto Rican, etc.)		lack, White	
<u>რ</u>	raf', c	1 by	3 ₩Widowed 4 Divorced	If Yes, Give Year or Dat	tes:	1 ☐ Yes 2 ♣No	Specify:		Spec	ity:Whi	.te
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23e or 28e-f show aumatic event, the Medical Examiner must be notified at	Completed		it's Education st grade completed)	16a. D	ecedent's Usual Occur	pation during most of w	orkina	16b. Kind of	Business/	Industry
2	Athin ne.	mpi	Elementary/Secondary (0-12)	College (1-4	40r 5+)	Give kind of work done fe. DO NOT use retire	d)	9			
2	led w tygier her ti		12	I soul		lerical	40 14 11 1 11				of Justice
anc	be fi	Be	17. Father's Name (First, Middle,				18. Mother's Na	ame (First, Middle,	Maiden Suma	ime)	
3	should and Men marke umatic	To	William H. Von					ret Dunk			
Maryland	ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic					Mailing Address (Street					
_	1 and 2 Health tem 27		Barbara J. Stev 20a. Method of Disposition	rens / Daug	thter 646	1 Hawkins isposition (Name of	Gate Roa	id, LaPla	ta, Maj		
סַ	Pages nent of int: If its iry or o		1 Burial 2 Cremation		tate cemetery,	crematory or other pla	´ I				
altimore,	it. Pi		'4 Donation 5 Other (S		Joy Cha	pel Cemete					Maryland
Ba	permit. Page Department Important: If any injury or once.		101111111111111111111111111111111111111	Du 1	W00050	22. Name and Addre					
			Edward N. Brins 23a. Part 1. Enter the disease, or	sfield, Jr.						1, MD	20650-0279 Approximate
Ь			shock, or heart failure. List Immediate Cause (Final	only one cause on each	ch line.	and the second	Control of the	2000 400 40 0 400 000	and the same of	in	Interval Between Onset and Death
ı	Pnysician /Medical		disease or condition resulting in death)	a. AWI	r as a consequence of)		CHAIX	OURSE	unl	UM	E YEARS
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	cuted nd ransit	Examiner	that initiated events	s							
ó	an ar an ar irial-ti	Ex	resulting in death) Last	Due to (or	r as a consequence of)						
8760	death certificate be executed e attending physician and id for use as the burial-transit	dicai		d							
9	antifica ing pl e as t	Med	IF FEMALE:	1		л.				+	
Вох	eath certific attending p	hysician/Me	23b. Was decedent pregnant	1 Live birt	ome of pregnancy th 2 Tetal death	3 ☐Ectopic pregnanc	y			ate of deliv	very Day Year
o.	at the dea by the a tached f	sic	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	4□Pregnar 9□ Unknow	nt at time of death vn	5 Other (specify)				Ontri	Day rear
۵.	hat thad that the	0	Part II. Other significant condition	Ons contributing to dea	th but not resulting in th	anderwing cause an	on in Part I	23a Did to	hacca usa con	atributo to	the cause of death?
ď,	The law requires that the ste has been signed by thoage 2 should be detache	1 by	, and its origination of the contract of the c	mo outilibrating to dea	an bat not resulting in th	ie underlying cause giv	HIFAILI.		es 2 No		bably 4 □Unknown
ecord	requ been shoul	etec			1			-			
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		O							2 No	1 Yes	2 M No
Vital		Be	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only or			
ō	Phys this ral di	. To	1 Yes 2 No 27. Manner of Death	28a. Date of		Itlent 3 DOA	4 Nursing	Home 5 Reside			ity)
	ttending F death. tor: After the funer	tion	1 Natural 5 Pendin	g (Month,	Day Year) Inju	ry Wor	k? Yes 2 □ No	200. Describe III	ow injury occu	1160	
Division	or Attendi after death. Director: A in by the fu	fica	3 Suicide 6 Could	not be	f Injury - At home, farm			28f. Location (Si	treet and Num	ber or Rui	ral Route Number,
2	after Direct	Certification;	4 Homicide determ	building	, etc. (Specify)	, 4.1.501, 14.0101, 011100		City or Town	n, State)	00, 0, 1,0,	ar riodio rvamper,
	e Hospitel 124 hours a e Funeral (letely filled	alc	29a. Certifier 1 Certifyin	g Physician: To the b	est of my knowledge, d	eath occurred at the tir	ne, date and place	e, and due to the c	ause(s) and m	anner as	stated
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune completely filled in by the fune	ledical	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examination and/o	r investigation, in my o	pinion, death occ	urred at the time, d	ate and place	and due t	to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifie	ſ		29c. Licens			9d. Date sign		
	care		D /// 9		-20	D-1	8545	SA	UGUS	1	1, 2005
	10			who completed cause	of death (Item 23a) (Ty	pe, Print)				4	
	¥.		P. WISOTSKY	W(1). 12	er a	1) UNE	CENTER	WHE	XXF,	Md	1, 2005 . 20602
	Sta		31. Date filed (Month, Day, Year)	1 2 2005 3 2. Reg	gist of Signature				,		
	Registr	all .	Rou	T to COO 3	CONTRACT SO	A STATE OF					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Antonia May Nicholson 11:45 a.m. 6, 2005 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lexington Park

1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 48816 Bay Forrest Road St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 □ M 2 F Director 150-34-6848 60 May 23, 1945 New Jersey Usual Residence of Decedent death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland St. Mary's Lexington Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or Items 23a 48816 Bay Forrest Road Funeral 20653 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ified within 72 hours after de l'Hygiene.

Other then "naturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates: þ Specify:White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) perriit. Pages 1 and 2 should be filed win Department of Health and Mental Hygiene Important: if Item 27 is marked other the any injury or other traumatic event, Italy 2006 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Tony Repici Elsie May Higgs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Nicholson / Husband P.O. Box 83, Dameron, Maryland 20628 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre. 8-9-2005 Charlotte Hall, MD 21. Signature of Superal Service Journal Service Library Service Servi 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deat Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) tha deteched 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Po 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Division of Vital 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case refe nedical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 PNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t Natural 5 Pending efter death.

Director: Af
d in by the fur t ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C filled d 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ţ, 29b. Signatue 2 29c. License number 29d. Date signed (Month, Day, Year) D31952 8-8-2005 30. Name and address of per rin | o completed cause of death (Ite | ype, Print) 5 M.S. Szkotnicki, M.D., 22576 MacArthur Boulevard, California, MD 20619 32. Registar's Signature State 2005 A Septem Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Pauline Evelyn PRYOR 2005 Hugust /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Washington Hagerstown 7. Age (In yrs. last birthday)
85 Yrs.

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Days | Hours | Min. | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | May 12, | 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** ^Y27920 1 ☐ M 2 🖾 F Pennsylvania 216-14-5500 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b, County th and Mental Hygiene. ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Eran is at must be notified at 1 Yes 2 □ No Director Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21742 109 Cedarwood Drive Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours affer in ant of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) dress factory 0 presser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minerva I. Householder Harry M. Cosgrove ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harold J. Cosgrove - brother 1008 Potomac Avenue, Hagerstown, Maryland other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Important: If any injury or once. Cedar Lawn Memorjalk Hagerstown, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 Part . Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prenning **Physician** 2 wn disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) □Yes 2□No 9 Ulnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Ulaknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 4 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Netural 5 Pending after death.

Director: Af
d in by the fur 1 Yes 2 No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D 1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ena mo D (8019 AV 67, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hop-Md 2-140 340 mill 31. Date filed (Month Agarg 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGUST PORTER 2005 2:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLOTTE HALL VETERANS HOME CHARLOTTE HALL ST. MARY'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**XX**M 2□ F Director Yrs. 324-14-4433 83 MARCH 28,1922 ILLINOIS Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23s or 28e-f show other treumatic event, the Mcdical Examiner must be notified at 1 Yes 2 No Director CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 DULLES STREET 20646 U. S. A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1XXYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo þ Specify 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CHIEF PETTY OFFICER U. S. NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be find and Mental H JOHN PORTER PAULINE TODD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an KATHERINE GREENE / DAUGHTER 6415 OCELOT STREET WALDORF, MARYLAND 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State AUGUST 5. permit. Pages 1
Department of H
Important: If Ite
any injury or ott 1 ☐ Burial 2XX remation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2005 BRINSFIELD-ECHOLS CR. CHARLOTTE HALL, MD 22. Name and Address of Facility AREHART-ECHOLS FUNL. HME., P.A. 21. Signature of Funeral Service Licensee Chief Moogg 211 ST.MARY'S AVE. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. A/2 hinis Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 1101-17 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) Ö 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, by 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 28c. Injury at Work? Hospitel or Attending 24 hours after death. 1_Natural 5 Pending М investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) 00 0 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MP 120 Hamd Hagothmn 100 Hospital Rd., Prince Frederick, Md. 20678 State Hour . AUG 0 8 2005 Registrar

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			1 - For State Registrar	State of M	laryland / Do	-	tment of He		nd Me		giene Reg. NØ	005	27301
	Physici /Medio	al	Decedent's Name (First, Middle, Last CL 4a. Facility Name (If not institution, give	ARA			ANDREU			2. Date of De Month AUG .	Day 2	2005	3. Time of Death
	Examir	er	WESTMINSTER NUR 5. Social Security Number 6. Se	SING HO	ME			MINS	TER		C	County of Dea	L
	Funeral Director				ge (In yrs. last birth	7/	Months Days	Hours		8. Date of Bir (Month, Da 3 / 1 7 /	1 9 1 5		thplace (State or Foreign ountry) RYLAND
	Maryland If show	tor	10a. State 10b. County MD BALTIMO	RE	10c. City, Town		STOWN				10d. Inside City Limits 1 ☐ Yes 🏋 No		
	with the sa or 28s	Director	10e. Street and Number				10f. Zip Code					zen of What Co	ountry?
920	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Medical Everial at mart to retified at	by Funerai	10 GLYNTREE GAI 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces 1 Tyes 2 M If Yes, Give Year or Dates:	?		2113 as Decedent of His res, specify Cuban Yes 2X No		in? (Spec Puerto R	ify Yes or No ican, etc.)		4. Race - Ame Black, Whit	
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Baltimore, Mary	t. Pages 1 and 2 rtment of Health a rtant: if itam 27 is rjury or other trau		19a. Informant's Name/Relationship (T) CALIOPE PAPANDR 20a. Method of Disposition 12 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. St. natur	EU-DAUG	HTER 10	GL crema EN	ion (Name of	GART	H,] Da	REIST	ERST 20c. Loc FIN	OWN Incation - City or KSBUR	MD. 21136 Town, State G, MD.
ä	Depring Import		23a. Part1. Enter the disease, or compl shock, or hear failure. List only o	ications that cause		254	E. MA	IN ST	Γ.,W	ESTMI	NSTI		
,8760,	death centificate be executed Wedical e attending physicien and dor use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of	Ji	ege utu V ulas a Uzhen			D.	rens	e	Inch 104
.O. Box 6		Physician/Me	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death		ctopic pregnancy other (specify)				23	3d. Date of deli Month	ivery Day Year
rds, P	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions con	ntributing to death I	out not resulting in the	he und	erlying cause given	in Part I.		23e. Did to			the cause of death?
al Record	The ate h page	Completed										24b. Were au prior to death?	topsy findings available completion of cause of
Ion of Vital	To the Hospital or Attanding Physician: within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director.	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpati 28a. Date of Inju (Month, Da	ury 28b. Tim	ne of	3 DOA Other 28c. Injury a Work?	4X Nurs	sing Home	Check on one of the control of the	lence 6	Other (Spec	sify)
Division	ial or Attandi s after death. ai Diractor: A ad in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, farm tc. (Specify)	n, street	t, factory, office		28	f. Location (S City or Tow	Street and m, State)	Number or Ru	ral Route Number,
	To the Hospital or Attant within 24 hours after deati To the Funarai Diractor: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best ner: On the basis of and manner st	of examination and/o	death o	ccurred at the time stigation, in my opin	, date and nion, death	place, an	d due to the o	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Σ	29b. Signature and title of certifier	And.	lleton m	Ö	29c. License r	442			8/2	signed (Month	n, Day, Year)
	A,2/		John W Middle	eton le	death (Item 23a) (Ty	h	rad W	atm	inste	VN	10	21157	4
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 3 2		rar's Signature	d	and s						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** HILDA CATHERINE POLSTER 30, 2005 12:30 A JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CARROLL MANCHESTER NORTH PINES ASSISTED LIVING If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 21X F 102 219-36-1596 Director MARYLAND 3/13/1903 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. toside City Limits 28e-f show traumatic avent, the Medical Examiner roust be notified at X□Yes 2□No Director ANNAPOLIS MD ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 230 2706 YEOMANS LANTERN CT. 21401 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ☐Yes 2X No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 0 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry t of Health and Mental Hygiene.
If itam 27 is marked other than
or other traumatic avent, Ire M. Elementary/Secondary (0-12) College (1-4or 5+) LICENSE PRACTICAL NURSE HEALTH 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be GROGG EBAUGH MARY WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY SUE BARILLA-DAUGHTER 2706 YEOMANS LANTERN CT., ANNAPOLIS, MD. 21401 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or once. ö * 4 ☐ Donation 5 ☐ Other (Specify) WESTMINSTER CEMETERY 8/3/05 WESTMINSTER, MD. Euneral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. Sonature 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician menta /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attanding Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a c Box 68760. Physician/Medlcai IF FEMALE: 23c. tf yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy þ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. be 1 Tyes 2 **P**No 3 Probably 4 □Unknown Completed page 2 should 24b. Were autopsy findings available prior to comptetion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 N director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) TTYTNO 0 1 Yes 2 No 3 DOA s after death.
I Director: After this of in by the funeral di LIVING 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Delural 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To tha Funaral I

completely filled filled Fo the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and 29d. Date signed (Month, Day, Year) MIL 30. Name and addi person who completed cause of death (Item 23a) (Type, Print تها Kaneus Date filed (Month, Day, Year) 32. Registar's Signature State Registrar AUG 03 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Shirley Ann Porter July 31, 2005 /Medical 16:30 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4933 Coronado Court Waldorf Charles If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 242-78-8058 1□M 2QF 59 Yrs. Director 9, 1945 Rocky Mount N.C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examination must be notified at 10d. Inside City Limits Director Maryland 1 Tyes 2 □ No Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4933 Coronado Court 20602 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: Black 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within in and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Accountant Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Murphy Ruby Lucas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: if item 27 i James Murphy, Jr. / Brother 618 Henry St. Rocky Mount, N.C. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 反 Removal from State ō Department important: if any injury or once. * 4 □ Donation 5 □ Other (Specify) Northwestern CemeteryAug, 9, 2005 Rocky Mount, N.C. 22. Name and Address of Facility
Alexander S. Pope Funeral Hones, P.A.
5535 Mariboro Pike/Forestville, Md. 21. Signature of Funeral Service Lice 20747 23a. Part1. Enter the of ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician heart Disease chemic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). attending physician and for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.0. 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an of Vital 2 7Na 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other 4 | Nursing Home | See Residence 6 | Other (Specify, tes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? i or Attending P after death. Director: After t 28d. Describe how injury occurred Division 5 Pending Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 400 DO0 50883 30. Nam, and address of person who completed cause of death (Item 23a) (Type, Print) wiresup 5 31. Date filed (Month, Day, Year) 3 Registrar's Signature State AUG 0 8 2005 Registrar

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1			Registrar 1. Decedent's Name (First, Middle, La	st)	Oe.	Tillicale Of	Dealii	2. Date of Dea	lag. Ng. 0 0 5	27307
	Physici /Medio		robet	· //	42			Month 08	Day Year	5 1250 M
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town	or Location of Death		4c. County of Dea	
			Eastrn ar	chosal	Inst	West	-0118		Some	-5-64
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Bit	thplace (State or Foreign ountry)
	Director		217-36-3607	ALM ZLIF	43 Yrs.			MAY 8,		HAMPSHIRE
	and *		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
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3	hours after tural', or Ite al Examine	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	WHITE
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	filed with Hygiene. Ithar thar	9	12		CONST	RUCTION	WORKER		CONSTRUC	TION
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yla	2 should be and Mental Is marked and marked and marked and and and and and and and and and an	မ	THOMAS	HOWE	PA	IGE	MARTHA	ELAINE	LETTEN	EY
Maryland	s 1 and 2 should i Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number	r, City or Town, State,	Zip Code)
	and ealth m 27		THOMAS H. PAIGE-		4307	COULBOUR			SBURY MD 2	
ore	ges 1 av 1 of Hea If item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, crea	osition (Name of matory or other pla		Date	20c. Location - City or	Town, State
altimore,	Pag iment tant: jury		' 4 ☐ Donation 5 ☐ Other (Special	y)	CREMATORY	OF DELMA	ARVA 8-6-	2005	DELMAR, DE	LAWARE
Ball	permit. Pages Department of Important: If i any injury or once.		21. Signature of Foheran Service Licer	isee	22	2. Name and Addre	ss of Facility B	OUNDS FU	NERAL HOME	
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н			23a. Pagri. Enter the disease, or comshock, or heart failure. List only	one cause on each line.	e death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Lille	Cirrh	0515				6 months
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):	^ /				(-1
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8760	cate be executed obysician and the burial-transit	aiE								
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9 X	requires that the death certific een signed by the attending p nould be detached for use as	/We	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of de	la cana
Вох	eath atter I for u	ciar	23b. Was decedent pregnant in the past 12 months?	1⊡Live birth 2 (4⊡Pregnant at tin	Fetal death 3	Ectopic pregnancy Other (specify)	/		Month	Day Year
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Division of Vital Records,	Attendi r death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could not b	286. Place of injury	- At home, farm, str	eet, factory, office			reet and Number or R	ural Route Number,
Ö	al or s afte	Certification;	4 Hornicide	building, etc. (Specify)			City or Towr	n, State)	
	hour hour unerally fille	cai (29a. Certifier 1 Certifying Pt	ysician: To the best of niner: On the basis of ex	ny knowledge, death	h occurred at the tir	ne, date and place,	and due to the ca	ause(s) and manner as	s stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	one)	and manner stated	1.					
i	To To	-	29b. Signature and title of certifier	AG D		29c. Licens			9d. Date sigged (Mont	n, Day, Year)
	UB		W) LA	10()		100	150826)	0/5/05	
	SAI		30. Name and address of person who		h (Item 23a) (Type, 3 0 44 20	Print) 7 Nonte 1/1	50826 I NEUC.	LD .11	870110 M	7 2/007
	Sta	te.	31 Date filed (Month, Day Year)	32. Rastrar's	Signature	, -uene	, rul	-4 VV-	-010W	X 1010
	Registr	ar	31. Date filed (Month, Day, Year) AUG 0 8	2005 Mereus	w # A	barle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amended item #7 per fh/wichd@ertificate of Deat/8-8-05/dls 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 3:18PM ELIZABETH 05 **PETRECCA** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1∏M 2XIF 77 88 Yrs. 217-24-0099 NOV. 25, 1927 WEST VIRGINIA Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Director **DELAWARE** FENWICK ISLAND SUSSEX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 MASON DIXON ANNEX 19944 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR 12 MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LAWRENCE LEDFORD BARTARM NANCY ETHEL BALDWIN ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARISSA J. STEPS/DAUGHTER 11 MASON DIXON ANNEX, FENWICK ISLAND, DE. 19944 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 8/6/05 DELMAR, DELAWARE 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 college) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONEUMONIZ 3 days disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying

Physician /Medical Examiner

Department of Health a important: if itsm 27 is any injury or other tra once.

Funeral

Director

or 28a-f shov

items 23a

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and Mental Hygiene.

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Pages 1

The law requires that the death certificate be executed

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after death

or Attending

Box 68760.

P.O.

Division of Vital Records,

other traumatic event, the Medical Examiner must be notified at

the Maryland

Maryland 2121

more.

Physician/Medical Examiner þ Completed Be 25. Was case referred to medical Certification: To 27. Manner of Death

examiner

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

1 ☐ Yes 2 ☑ No

5 Pending

investigation 6 Could not be determined

within 24 hours a Medical npletely State Registrar

Cause (Disease or Injury that initiated events resulting in death) Last	c
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown

5 Other (specify)

3 Ectopic pregnancy

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of

	performed? 1 ☐ Yes 2 ☑ N	o dea	Yes	2 12 No
C	heck onle one			
0	5 Residence	6 ☐Other (Speci	(ty)

Cther: 4 Nursing Hom 28c. Injury at Work? 28d. Describe how injury occurred

autopsy

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Phys Medical Examir	ner: On the basis and manner:	of examination	edge, dea n and/or i	ath occurred at the time, date and place, and investigation, in my opinion, death occurred	d due to the	e cause(s) and manner as stated. , date and place, and due to the cause(s)
of certifier	11	A	2	29c. License number		29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and manner stated.

DBERT DURKIN D.O.	9733	HEALTHWAY	DRIVE,	BERLIN,	MD	21811

1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

31. Date filed (Month, AUG 0 8 2005

28a. Date of Injury (Month, Day Year)

			for State	State of Marylan				lental Hyg	iene	
			Registrar		Cei	tificate of l	Death		eg. No. () () 5	27309
1	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Year	
86-	/Media		Chester A 4a. Facility Name (If not institution, give s.	1vin Pil	.e	4b City Town or	Location of Death	August	9, 2005 4c. County of De	7:40 a.m.
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	Funeral	7	5. Social Security Number 6. Sex	7. Age (In yrs. i	ast birthday)	If Under 1 Year	ardtown If Under 24 Hrs.	8. Date of Birth (Month, Day,	St. Ma	TY'S rthplace (State or Foreign Country)
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	72 hours after death with the Maryland natural', or items 23s or 28s-f show dical Exandiser must be notilled at	Funerai	44763 Woodlake Cot	2. Was Decedent Ever in U.	S. 13. V	Vas Decedent of Hi		ecify Yes or No-	United S1	
9	or item	Ξ	1 ☐ Never Married 2 € Married	Armed Forces? 1 Yes 2 No 194:	3-	Vas Decedent of Hi Yes, specify Cuba		Rican, etc.)	Black, Wh	
5-0036	ral', c	i by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1940	6 1	Yes 2 No	Specify:		Specify: Wh	nite
5	72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	ent's Usual Occupa kind of work done of OO NOT use retired,	ation Jurina most of work	ina	16b. Kind of Busines	s/Industry
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and	ntal hed od	Be					18. Mother's Nam		Maiden Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than sumatic event, the M	2	Orville Pile 19a. Informant's Name/Relationship (Typ	e Print)	10h Mailin	a Address (Street a		Little	City or Town, State.	7.0.4
Ma	id 2 s lih an 27 is trau		Mary Pile / Wife	o, , , , , , , , , , , , , , , , , , ,					, , , , , , , , , , , , , , , , , , , ,	zip Code) nia, MD 20619
ē,	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examiliser must be notified at		20a. Method of Disposition	20b. P		sition (Name of patory or other place			20c. Location - City o	
Baltimore,	Pages nent of I int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	movar nom State						
Ħ	그 된 관광		21. Signature of Juneral Service License	Bri	nsfield 22	I-ECHOLS Name and Addres	cre. 8-1.	2-2005 C	harlotte H Funeral H	Hall, MD
ñ	Depa Impo any in		Edward N. Brinsfiel	d. Jr. M000						20650-0279
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one							Approximate
	Physician		Immediate Cause (Final	cause on each line.	12.00		1//			Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a consequ	efice of):	wylas	luse	>		day)
19.	Examiner		0		10	PD				UNI
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):	111/00				1
	nd trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							0
00	e exe	E	resulting in death) Last	Due to (or as a consequ	ence of):					
68760,	icate be executed physicien and the burial-transit	edicai	d.							
_	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	/Me	IF FEMALE:	c. If yes, outcome of pregnar						
Вох	atten for u	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy			23d. Date of de Month	blivery Day Year
O.	that the de ted by the detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	14tii 5	Other (specify)				,
۵.	res that igned by be deta		Part II. Dther significant conditions cont	ribution to death by the resu	Iting in the un	derlying cause give	n in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
rds	quires n sign	d by	Carot	& Arlan	12			1 ☐ Ye	s 2 No 3 P	robably 4 Unknown
00	w requir	Completed	Porlah	anal Ward	nula.	19 2		24a. Was ar	24h Wara a	utopsy findings available
Re	The fav	E	1000011	was feet	coru	N.		autopsy	y prior to	completion of cause of
tal	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Death			s 2 🖲 No
of Vital Records,	Physician: this certificatal director,	To B	eyaminer?	spital: 1 Inpatient 2 6	ER/Outpatient	3□ DOA Othe		-	nce 6 Other (Spe	20(6)
	iding Physician: th. : After this certifica i funeral director, p		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho		(Solity)
Ö	endir sath. or: Af he fui	atic	1 Natural 5 Pending 2 Accident investigation	(month, bay roal)	mary		es 2□No			
Division	irector by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Str. City or Town	eet and Number or R	ural Route Number,
	itai o rel D									
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Medical Examine	cian: To the best of my know or: On the basis of examinati	vledge, death ion and/or inv	occurred at the time	e, date and place,	and due to the ca	use(s) and manner a	s stated.
	ths thin 2 ths mplel	Med	A	and mainner stated.						
			29b. Signature and title of certifier	Allaha	Mn	29c. License	7 / // 10	29	d. Date signed (Mon	
	SAR		James James	J. JAVNOE,	(H)	100	16417		8-11-	U5
	5		30. Name and address of derson who con	11		•	. , .a. 11_11	m	20626	
23	Sta	te.	J. Patrick Jarboe, 31. Date filed (Month, Day, Year)	22 Registr's Signat	ure		и, поттуу	vooa, MD	20030	
40	Registr	-	AUG 12	2005	B.	fort				

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	Physicia /Medic		Decedent's Name (First, Middle, Last) MARY	JANE	T 20	WELL	ı		Augi		B ^{ay} 2	2005	11:40 P M
}	Examin		4a. Facility Name (If not institution, give street and number, 1723 Monkton Farms Drive				Town, or onkto	Location of D	eath			ty of Death	re
	Funeral Director		216-05-2131 1□M 2∏F	ge (In yrs. la 93	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours I	Hrs. 8. Date Min. June	of Birth h. 9 ay 1 %	12	9. Birth Cou Mar	place (State or Foreign ntry) Yland
	ith the Maryland or 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll		, Town or Lo Taneyt								10d. Inside City Limits
	n with th	al Dire	10e. Street and Number 108 West Baltin	ore S	t.	10f. Zip	2178	37		10g.	Citizen of USA	What Cou	ntry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, I'm Medical Exp. Aret must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Was Decedent Armed Forces 1 Yes 2 Was Decedent Armed Forces 1 Yes 2 Was Decedent Armed Forces 1 Yes 2 Was Decedent Armed Forces	?		Was Decedif Yes, spec		spanic Origin n, Mexican, P Specify:	? (Specify Yes uerto Rican, et	or No-	Bla	ace - Ameri ack, White, ify: Wh:	etc.
21215-0036	vithin 72 hours ne. han "naturat", e Medical Exa	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+)	life.	dent's Usua kind of wo DO NOT us	rk done a se retired	luring most of)	working			Business/Ir Dealei	
	should be filed within the Mental Hygiene. In warked other than matte event, I'le Mentalle event, I'le Mentalle event, I'le Mentalle event, I'le Mentalle event, I'le Mentalle event, I'le Mentalle event, I'le Mentalle event, I'le Mentalle event, I'le Mentalle event, I'le Mentalle event, I'le Mentalle event, I'le Mentalle event, I'le Mentalle event, I'le Mentalle event, I'le Mentalle event	Be Co	17. Father's Name (First, Middle, Last)	المدحد عاما					Name (First, A	iddle, Maid	ten Suma	ime)	siip
Maryland	and Mental Paramed of Sumarked of Sumarked of Sumarked of Sumarked of Sumarked of Sumarke over	2	William E 19a. Informant's Name/Relationship (Type, Print)	awara				and Number o	Lic or Rural Route I	aura] Jumber, Cit			o Code)
	1 and 2 s Health ar tam 27 is		Patricia L. Sloop/niece	205 BI	1409	Thoma	as R		, Belai:	r, MD	210	015	
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1	Gra	ace of Dispo emetery, crea CE UCC	C Ceme	etery		g.13,20)5 Ta	aneyt	· · · · ·	Maryland
Bal	permit. Departr Imports eny inji		21. Signature of Funeral Service Licensee MC 23a. Part 1. Enter the disease, or complications that cause	0534	13	36 E.	Balt		Skiles St., Ta	neyto			21787-2182 Approximate
8760,	behavioral the death certificate be executed Wedgread We as the buriar-transit By the attending physician and the buriar-transit The provided by the detached for use as the buriar-transit	dicai Examiner	shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a Due to (or a d.	GEST s a consequ D s a consequ	ience of):	<i>I</i> -	lea r	?T	FAILU	RE			Iniervat Between Onset and Death
.O. Box 6	the death certific y the attending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown 9 Unknown	2 Fetal	death 3	Ectopic pi Other (sp						ate of deliv	ery Day Year
<u>a</u>	quires that the de n signed by the a ald be detached f	by	Part II. Other significant conditions contributing to death	but not resu	Ilting in the u	nderlying o	ause give	en in Part I.	23e.	Did tobacc		ntribute to	he cause of death?
I Records,	The law ate has b page 2 st	Completed	CELLULITIS LE	95					-	Was an autopsy performed	1?_	were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available omptetion of cause of
Vita	ysician: This certificate director, pag	To Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpat	ient 2 🗆	ER/Outpatie	at 3 0 00	Othi		Death (Check	only one)	T	ther (Speci	Friends
Division of Vital	or Attending Ph Itier death. Director: After th in by the funeral	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	ury ay Year)	28b. Time of Injury	f A	28c. Injun Work		28d. Des	cribe how i	njury occu	urred	Home al Route Number,
	the Hospital hin 24 hours a the Funeral I mpletely filled	Medical C	29a. Certifier 1 Certifying Physician: To the bes (Check only one) 2 Medical Examiner: On the basis and manner s	of examinat	wledge, deal	h occurred vestigation	at the tim	ne, date and pointion, death	place, and due to courred at the	o the cause time, date	e(s) and n and place	nanner as	stated. o the cause(s)
	To the within To the Comp	Σ	29b. Signature and title of certifier		. 5.	3	_	s number S45	80	29d.	07	red (Month)	Day, Year)
	15		30. Name and address of person who completed cause of WASIM FAKHAR, M.D., 4/7	death (Item	BALT	Print)	T F	# D	TANE	YTON	SN	MD	21787
8	Sta Regist		31. Date filed (Month, Day, Year) 32. Regis	trar's Signa	ture miller								

DHMH 17 Rev 1/2001

	Please Type or	Print in Blac	k Ind	lelible Ink	. Ensure	All Copies	s Are	Legible	•
	State of	of Maryland / [Depa	rtment of H	lealth an	d Mental Hy	/giene	Э	
	1 - State Registrar		Cert	tificate of	Death		Reg. No	000	07011
	Decedent's Name (First, Middle, Last)					2. Date of De	eath Z	y Yea	3. Time of theath
n	Richard Louis Ponsini					August			
ai er	4a. Facility Name (If not institution, give street and nu	mber)		4b. City, Town, o	r Location of D	eath	4c.	. County of De	
	Ruxton Health of Denton			Dei	nton			Caroli	ne
	5. Social Security Number 6. Sex	7. Age (In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8. Date of Bi			Birthplace (State or Foreign Country)
	114-28-0975 ¹ X ¹ X ² □ F	68	Yrs.	Months Bayo	110010	Aug 2	5 19	38 N	ew York
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Loo	ation					10d. Inside City Limits
<u> </u>	Tob. County	Toc. City, Tow	II OI LOC	ation					1X Yes 2 □ No
çç	Maryland Caroline	Gree	nsbo	T					
=	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What	Country?
<u>.</u>	12443 Gardner Lane			21639			USA		
Funeral Directo	Amed Fo		13. W	Vas Decedent of H Yes, specify Cub	lispanic Origin' an, Mexican, P	(Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Ar Black, W	merican Indian, hite, etc.
	1 Never Married 2 Married 1 X Yes If Yes, Gi 3 Widowed 4 Divorced Year or D	2 □ No ive Dates: 1958-95	1	☐ Yes 2X No	Specify:			Specify:	
g D							101 15		White
ete	15. Decedent's Education (Specify only highest grade completed)		(Give k	ent's Usual Occup kind of work done OO NOT use retire	during most of	working	16D. K	and of Busine	ss/industry
Completed by	Elementary/Secondary (0-12) Cotlege (1-4or 5+)		luction (Ма	nufact	urino
ပ္တ	17. Father's Name (First, Middle, Last)					Name (First, Middle			
0 86	Louis Ponsini				Emmi	Page Pon	sini	,	
Ĕ	19a. Informant's Name/Relationship (Type, Print)	19b	. Mailing	Address (Street		r Rural Route Numb			a. Zip Code)
	John Ponsini/ son					reensboro			
	20a. Method of Disposition			sition (Name of atory or other pla		Date	_		or Town, State
	1 X Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State				~ 16 2005	77	11-	Mawri am i
	21. Signature of Funeral Service Licensee	Easter		Name and Addre		g 16 2005	nur	TOCK,	магутано
	Multel		Fle	egle and	l Helfe	nbein Fun	eral	Home,	PA
_	23a. Part1. Enter the disease, or comptications that	caused the death. Do				boro, MD		9	Approximate
	shock, or heart failure. List only one cause on Immediate Cause (Final	each line.	0	1					Interval Between Onset and Death
	disease or condition resulting in death)	HRPNIC		ENA2	+AIL	NRE ISEAS			MONTHS
	Due to	(or as a consequence	of):	KIDNI	T	C-16	/.		11/200
<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to	(or as a consequence	of):	KIDN	cy w	1 SEAS			YEITICS
Examiner	Cause (Disease or injury	(0. 00 0 00.100400.100	0.7.						
xar	that initiated events c.	(or as a consequence	of):						
<u>8</u>									
	d								
Š	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, ou	itcome of pregnancy						23d. Date of o	delivery
clar	in the past 12 months?	birth 2 Fetal death nant at time of death		Ectopic pregnance Other (specify)	<i>'</i>			Month	Day Year
ysi	9 Unknown 9 Unkr	nown							
y P	Part It. Other significant conditions contributing to c	death but not resulting in	n the un	derlying cause gr	en in Part I.	23e. Did	tobacco i	use contribute	to the cause of death?
Completed by Physiclan/Medic	DIABETES, HM	427 ENSIO	7	DYSLIP	IDEMI	<u>√</u> 1□	Yes 2	□No 315	Probably 4 DUnknown
lete	,)			24a. Was	an	24b. Were	autopsy findings available
dmc						auto perf	ormed?	prior t death	o completion of cause of
ပို	25. Was case referred to medical				OR Dinon -f	1 Yes	25 No	1 U Y	es 20 No
_	EU. TTUS OUGO IOTOTIOS TO HITOSIOSI				ZO. FIRCE OF	Death (Check only	UTTE)		

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturat", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinat must be notified at agree. Once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

1 Yes 2 No Manner of Death 1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 - Homicide

5 Pending investigation

28a. Date of Injury (Month, Day Year) 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Intury

Other: 4 Versing Home 5 Residence 6 Other (Specify) 28c. tnjury at Work? 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

REINIBOUS, WIN

28d. Describe how injury occurred

Certifying Physician: To the	best of my knowledge, death oc	curred at the time, date and place, and due to the igation, in my opinion, death occurred at the time.	ne cause(s) and manner as stated.
and man	ner stated.	igation, in my opinion, down occarros at the time	o, date and place, and doo to the odeso(s)
Me of certifier	1 21 -11	29c. License number	29d. Date signed (Month, Day, Year)
0/1///	HTE NOWO	100 ES 000	オーバーのヤー
1. Many	MI	1100000	0 15 -5

29b. Signature and type of certifier	29c. License n	umber	Λ.	_
All All ATTEMOTOR	1000	23	040	-
MAN POWER IND	100	-		1
30 frame and address of person who completed cause of death (ttem 23a) (Type, Print)	DAYL	M. 1	CEINE	5
^ /	rais		26	
2-1 00-0011-0	7	1200		_

31. Date filed (Month, Day, Year)

AUG 1 5 2005

Registrar's Signature

FEDRALS BURL

State Registrar

Medical Certification: To

			1 - For State Registrar	State of Maryla		artment of I			giene) 5 2	731	2
	Physici		Decedent's Name (First, Middle, Las John Edward	Ridgley				2. Date of Dea Month August	Day	Year 2005	3. Time of 3:33	Death P M
	/Medi Examir		4a. Facility Name (If not institution, give Montgomery Hospi	street and number)	e		or Location of De		4c. Coun	ty of Death		
	Funeral Director		213 42 7300	x 7. Age (In yr XM 2□F 61	s. last birthday) Yrs.	If Under 1 Year Months Days				9. Birthp	ace (State of try) Land	r Foreign
	he Maryland 28a-f show otffled at	ector	Usual Residence of Decedent		ontgomen	y Villag	ge				0d. Inside Ci	
(0	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event. The Medical Examinar must be notified at	Funeral Director	9 Butterwick Cour 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑No			Hispanic Origin? Pan, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Unite		es an Indian,	
Maryland 21215-0036	thin 72 hours a e. an "natural", o Medical Evan	Completed by	3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	If Yes, Give Year or Dates: Ication (e completed) College (1-4or 5+)	16a. Dece	1 Yes 2 No dent's Usual Occu kind of work done DO NOT use retire	nation	vorking	Spec	wni		
land 21	2 should be filed within and Mental Hygiene. Is marked other than " aumatic event, the Me.	To Be Con	17. Father's Name (First, Middle, Last) George Ridgley	5+	Defec	cts Safet	18. Mother's N	eer lame (First, Middle, sa Romano	Automo Maiden Suma			
	ss 1 and 2 should of Health and Men Item 27 Is marke r other traumatic		19a. Informant's Name/Relationship (7 Joseph Marella -	Son-in-law	10241	Crosscut		Rural Route Number amascus,			Code) 872	
Baltimore,	t. Page rtment o rtant: If njury or		20a. Method of Disposition 1	Removal from State	11 Soul	sition (Name of matory or other pla s Cemete	ry Aug	Date 5. 11,200.		antow		y1and
Bal	Depar Impor any Ir		21. Signature of Funeral Service Licens	Upen	2	6401 Rid	ge Road,	h P.A Fur Damascus	s, Mary	_	20872	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, lany leading to immediate cause. Enter Underlying Cause, (Disease or injury)	a. Metastatic Due to (or as a conso	Colon equence of):			ac or respiratory at			Approximate Interval Bett Onset and E	ween
Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medicai Exan	resulting in death) Last	Due to (or as a const d	nancy	Ectopic pregnanc	у			ate of deliver	*	'ear
P.O.	s that the de ned by the a e detached f	by Physic	1 Yes 2 No 9 Unknown Part II. Other significant conditions co	4□Pregnant at time of 9□Unknown ntributing to death but not re		Other (specify)	ven in Part I,	23e. Did to	bacco use co			
Vital Records,		Completed b						24a. Was autop	SV	Were autop prior to con death?		available
of	Attending Physiclen: T r death. ector: Atter this certificel by the funeral director, p.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	ner: 4 🗆 Nursing	eath (Check only of Home 5 Resid 28d. Describe h	ence 6 XO		Hospi	ce
Division	ital or Attenors after death al Director; led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rural	Route Numi	70 <i>r</i> ,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Medical	one) 2 Medical Exam	sician: To the best of my ki iner: On the basis of examinand manner stated.	nowledge, death	vestigation, in my	opinion, death oc	curred at the time, o	date and place	, and due to	the cause(s)	
)		<	29b. Signature and title certifier	the		29c. Licen:	se number 11218		29d. Date sign	ed (Month, E	Pay, Year)	
	15		30. Name and address of person who con Charles Harrison	6001 Munca	ster Mi	*	Rockvil	lle, Mary	land 2	20855		
	Sta Registi		31. Date filed (Month, Pay Year) 05	32. Registrar's Si	pature	E.						

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Katherine Victoria Robinson 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Doctors Hospital Lanham Prince George | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year | Dec. 26, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F 168-40-8927 55 1949 Pennsylvania Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural; or Iteme 23a or 28e-1 show any injury or other treumatic svent, the Medical Evantment must be notified at once. 28e-f show 1 ¥Yes 2 No Maryland | Prince George Riverdale Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6815 Riverdale Rd.#G2 20737 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black ş 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Rich Flora Davis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin R. Robinson, Jr SPouse 6815 Riverdale Rd. #G2; Riverdale, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Aug. 5,2005 Clinton, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, Md. 23a. Part1. Enter the disease corr shock, or heart failure ast only complications that caused the death, only one cause on each line. Approximate Interval Between Onset and Death be-not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Priysician TOR /Medical Due to (or as a consequence of) Examiner MONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner OF FINGERS the Hospitel or Attending Physician: The law requires that the death certificate be executed RENE nding physicien and Division of Vital Records, P.O. Box 68760 Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 2 Yes 2 7 No 3 Ectopic pregnancy Month Day 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SYNDROME 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 Landover Koad 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 0 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

BINSON,

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State of Maryland	Department of Health and Mental Hygiene	

			For State	State of Maryl	-		of Healt of Dea					
			Registrar 1. Decedent's Name (First, Middle,	Last	Cel	lincate	OI Dea	tu i	2. Date of De	Reg. No.	005	273
	Physicia /Medic		Thomas	Early	Reeve	es			Month August	Day 2	Year 2005	10:51A ^M
	Examin		4a. Facility Name (If not institution, g	give street and number)			own, or Locat			4c. (County of Dear	
			3629 Tyrol Drive				pringd				ince Ge	
	uneral irector		5. Social Security Number 236-22-1861	1771 M 2□ F	yrs. last birthday) 80 Yrs.	If Under 1 Months	Year If Ur Days Hou	nder 24 Hrs. urs Min.	8. Date of Bird (Month, Da Decemb			thplace (State or Foreign buntry) t, Virginia
מי			Usual Residence of Decedent						Decemb	ELZ	1 1 1 1 1 1 1	
rylan	how		10a. State 10b. County	100	. City, Town or Lo	cation						10d. Inside City Limits
e Ma	3e-f	cto		Georges	Springd	ale						1 ☑ Yes 2 ☐ No
ith th	or 2	Director	10e. Street and Number			10f. Zip (•	en of What Co	ountry?
ath w	238	ra	3629 Tyrol Driv				0774				S.A.	
er de	ltems per :	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decede If Yes, speci	ent of Hispanio fy Cuban, Me:	c Origin? (Spo xican, Puerto	ecify Yes or No Rican, etc.)	- 1	4. Race - Ame Black, Whit	
tiled within 72 hours after death with the Maryland	al', or	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 NoA If Yes, Give Year or Dates:	Lriorce	1 ☐ Yes 2	No Spe	ecity:			Specify:	Black
2 Po	natur Ical	ted	15. Decedent's	Education	16a. Dece	dent's Usual	Occupation done during	most of work	ina	16b. Kir	nd of Business	/Industry
thl	Med .	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	e retired)					
9d wi	1	Cou		4 yrs	S	pecia	1 Inve				ernment	
d be file	ked oth	To Be	17. Father's Name (First, Middle, La Zack Reeves	est)					Lee Ma		Sumame)	
shou	mar	ι-	19a. Informant's Name/Relationshi	o (Type, Print)	19b. Mailir	ng Address	(Street and N	umber or Rura	al Route Numb	er, City or	Town, State,	Zip Code)
nd 2	27 ls		Natalie A. Reev	es/Wife	3629	Tyro1	Drive	Spring	gdale,	Mary	land 20	774
s 1 a	ten other		20a. Method of Disposition		b. Place of Dispo cemetery, crer	osition (Nam	e of her place)		Date	20c. Lo	cation - City or	Town, State
Page	int: If		1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		liverdale			8/4/	05	Rive	rdale,N	Maryland
permit.	Department or result and weight raygens. Department of result and weight raygens any injury or other traumatic event, the Modical Examinations to notified at once.		21. Signature of up al Sovice Li	censee	1		Address of F	· J	. B.Jen			
	-		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused the							nary ra.	Approximate
Phy	ysician		tmmediate Cause (Final		stive Hea							Interval Between Onset and Death
//\	ledical		disease or condition resulting in death)	Due to (or as a cor		art ra	TIGIC					
Ex	aminer	L	Sequentially list conditions,		tensive	Cardio	vascul	ar Dis	ease			
pel	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor Diabe	nsequence of): tes Mell	itus						
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ificat	g phy as the	ed		3.								
5 6	esn .	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		⊒Ectopic pre	onancy			2	23d. Date of de	,
The law requires that the death certificate be executed	s been signed by the attending should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time 9☐ Unknown		Other (spe					Month	Day Year
that th	ed by detac		Part II. Other significant condition	s contributing to death but no	t resulting in the u	ınderlying ca	use given in f	Part I.	23e. Did t	obacco u	se contribute to	o the cause of death?
w requires	n sign Jd be	d by							1 🗆	Yes 2	□No 3□P	robably 4XJUnknown
5 ×	s bee	olete							24a. Was		24b. Were a	utopsy findings available
The	s certificate has b lirector, page 2 s	Completed							auto perfo	ormed?	death?	completion of cause of
	rtifica stor, p	0	25. Was case referred to medical				26. 1	Place of Deat	h (Check only			
l V	direc	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DO	A Other: 4[☐ Nursing Ho	me 5 ∑ Resi	dence 6	G □Other (Spe	ecify)
Attending Physician:	n. After this funeral di		27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28	Bc. Injury at Work?		28d. Describe	how injury	y occurred	
Attending	death. ctor: A y the fu	catl	2 ☐ Accident investiga	ation		М	1 🗌 Yes					
DIVI I or Att	affer deati Director: I in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin		At home, farm, st pecify)	reet, factory,	office		28f. Location (City or To			ural Route Number,
In Hospitel	within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	(Check only 2 Medical E	Physician: To the best of my xeminer: On the basis of exa	y knowledge, deat mination and/or in	th occurred anvestigation,	at the time, da in my opinion	ite and place, , death occur	and due to the red at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
i i	thin 2 the mplet	Med	one) 29b. Signature and title of certifies	and manner stated.		290	License num	ber		29d Date	e signed (Mon	th. Dav. Year)
10	₹		255. Signature and little of Certified	March	11.0	2	D280				ust 4,	
0	(1)		Therene (11. (115)5-01	your son The	/)	2200			-106		
	10/		30. Name and address of person w		•		033111 -	Dec #	D - 1 ·		34. 7	1 20704
	St	ate	Francine Hi 31. Date filed (Month, Day, Year)	ggs-Shipman M. 32. Registrar's S	J) II/U(o pert	sville	prive	peltsv	ılle	,Maryla	and 20/04
	Renist		AUG 0 8 200		b do							

	-	For State Registrar Amended #5	State of Maryla				Mental Hygi 11/05 същ		
		1. Decedent's Name (First, Middle, L		Oe.	illicate of	Dealif	2. Date of Death Month	2005	23. Time of Diearth
Physicia /Medic		Catherine Ile					Aug.	03 2005	11:52A. M
Examin	er	4a. Facility Name (If not institution, g 121 Phoenix Cou			Walkersv	r Location of Death		4c. County of Deat	n rederick
Funeral Director		5. Social Security Number 5.78-42-8056 5.78-32-5662		rs. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) ebruary	9. Birt Year) 9. Birt 16,1935Mar	thplace (State or Foreign buntry)
and	}	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside Çity Limits
Maryl F sho	tor	Maryland Frede	rick	Walkers	sville				1 🗗 Yes 2 🗆 No
h with the 23a or 28e st be rict	ai Directo	10e. Street and Number 121 Phoenix Cour	t		10f. Zip Code 21793		10	g. Citizen of What Co	ountry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show eny injury or other treumatic event. The Medical Ever'll at It, ust be rediffed at QRE8.	y Funerai	11. Marital Status 1 Never Married 2 Married	If Yes, Give		Was Decedent of H If Yes, specify Cub: 1 ☐ Yes 2 No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
"neturel",	leted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's (Specify only highest g		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	king	6b. Kind of Business/	hite Industry
filed within Hygiene. ther then int, the M	Completed	Elementary/Secondary (0-12) 9 17. Father's Name (First, Middle, La.	College (1-4or 5+)		nier		ne (First, Middle, M.	Automotive	
lid be lental ked o ic eve	To Be	Thomas Roy Walke	,				Morgal		
nd 2 shou alth and M 27 Is mai		19a. Informant's Name/Relationship Kathleen Via - I			•			City or Town, State, 2 erick, Mar	, ,
Pages 1 a ent of Hec nt: If item ry or othe		20a. Method of Disposition 11 Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Special Control of	☐Removal from State	b. Place of Dispo cemetery, crei	matory or other plac	8-6-2		oc. Location - City or Walkersvil	Town, State
permit. P Departm Importer eny injur		21. Sign up re of Funeral Service Go	ensee	- 2	2. Name and Addre	ss of Facility	Stauffer	Funeral Ho	
Pnysician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each line.			ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or as a cons	sequence of):					1 (0(1)
Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons		e enc	done	triol	C7	6 00
icate be executed physician and s the burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):					
E One	Medicai	IF FEMALE:	0.						
that the death certified by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify) _	1		23d. Date of del Month	ivery Day Year
es ign be	by	Part II. Other significant conditions	contributing to death but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
The law requir ate has been si page 2 should	Completed						24a. Was an autopsy perform	ed? prior to death?	itopsy findings available completion of cause of 2 No
Physicien: The k r this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		at 30 DOA Oth	00	th (Check only one		
ling After Tune	tion; To	1 Yes 2 10 27. Manner of Death 1 Natural 5 Pending investigat	28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of Injury	of 28c. Injur	4 Nursing n	ome 5 ☐ Pesiden 28d. De cribe how	nce 6 Other (Spectro) occurred	cify)
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To the Hospitel or Attending Phwithin 24 hours attended to the Funerel Director. After the completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Medicel Ex	Physician: To the best of my eminer: On the basis of exam and manner stated.	knowledge, deat nination and/or in	th occurred at the tir evestigation, in my o	me, date and place pinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as te and place, and due	s stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (Mont	h, Day, Year)
, ((9	7 01	4626		407 4	2005
10		30. Name and address of person when $50 / W$	e completed cause of death (Α	Print)	Frede	rick	MD 2	1701
Sta Registr		31. Date filed (Month, Bay Year)	5 2005 32. Redistrar's Si		And .		, ,		, , , , , , , , , , , , , , , , , , ,

			1- For State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. N						
			1. Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death					
	Physici	an	an Month D	Day Year					
	/Medic			3, 2005 4:26 P M					
	Examin	er		•					
	Funeral		Northampton Manor Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	Frederick 9. Birthplace (State or Foreign					
п	Director		5. Social Security Number 282-26-3330 6. Sex 1 Months 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) Yrs. 7. Age (In yrs. last birthday) Yrs. 7. Age (In yrs. last birthday) Yrs. 7. Age (In yrs. last birthday) Yrs. Months Days Hours Min. DEC. 4, 193	9. Birthplace (State or Foreign Country) 0hio					
Н	ס	_	Usual Residence of Decedent	T OHIO					
	irylan show		10a. State 10b. County 10c. City, Town or Location	10d. tnside City Limits					
	Ba-f	cto	Maryland Frederick Frederick	1 ☐ Yes 2 No					
	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-f show for Medicul Exeminar must be notified at	To Be Completed by Funeral Director	10g. Classification	Citizen of What Country?					
	ath v		8319 Legg Road 21704 Un	ited States					
	er de item		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.					
36	rs aft		1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:	Specify:					
Ş	ture sture		15. Decedent's Education 16a. Decedent's Usual Occupation 16b.	White Kind of Business/Industry					
7	n n n		(Give kind of work done during most of working life. DO NOT use retired)	Tand or business/mustry					
2	d with		Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Pr	ivate Practice					
פ	e file Il Hyg othe								
lar	uld by Aenta rked tic en		Kenneth McFadden Elosie Pe	rkins					
Baltimore, Maryland 21215-0036	12 should be filed within h and Mental Hygiene. 7 is marked other than " freumatic event, the Me.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City	or Town, State, Zip Code)					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, it a Medical Examinat must be notified at once.		Kevin J. Rich / Son 8319 Legg Rd. / Frederick, Mar	yland 21704					
	of He fiten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. □ Date 20c. □ Date 20c. □ Cemetery, crematory or other place)	Location - City or Town, State					
<u>Ĕ</u>	permit. Pages Department of i Important: if its any injury or o		Donal 2 Oremation o Inemoval from State	derick, Maryland					
a	pparti porti y in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Fund	eral Homes, P.A.					
<u> </u>	897.		Saymond I elerson 1621 Opossumtown Pike/Freder	ick, MD 21702					
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.	Approximate Interval Between					
	Physician		tmmediate Cause (Final disease or condition Intentinal Abortuition	Onset and Death					
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	overs					
	Lxammer	. bo	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	gans					
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
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687	ficate p physis the	edic	d						
Box	death certifica attending ph d for use as th	N/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery					
ă	death atte	Certification; To Be Completed by Physician/Medical	in the past 12 pronths? 1	Month Day Year					
0	t the or		9 Unknown						
S, D	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as			use contribute to the cause of death?					
Ë	quire en sig		B Kecto vaginal fistula secent 10 Yes	No 3 Probably 4 □Unknown					
Record	aw re		Depticema, Schizophienia 24a. Was an	24b. Were autopsy findings available					
Ä	hysician: The law his certificate has t I director, page 2 s		autopsy performed? 1 ⊤ Yes V N	prior to completion of cause of death? 1 □ Yes 2 □ No					
Viital			25. Was case referred to medical	o 1 Yes 2 No					
	nysic pis ce direc		Hospital: 1 Innationt 2 F8/Outnations 2 DOA Other Williams 5 Docides	6 ☐Other (Specify)					
Division of	ng Ph fter th neral								
	endii eath. or: Al		2 Accident investigation M 1 Yes 2 No						
ž	i or Att after de Directi	ıtı K	3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Could not be determined 5 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	urs at								
	Hosp 24 ho Fune itely fi	edical	29a. Certifier (Check only one) 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(some one) 20 Medicat Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manager statement of examination and/or investigation.	s) and manner as stated. Id place, and due to the cause(s)					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Med	S 001 0: 1 1:0 1 1:0 1	ate signed (Month, Day, Year)					
	⊢ s ⊢ ŏ) (.11. 11/08/2016/11/20 DZC102 /2	All some					
	GI		30. Name and address of person/who completes cause of death (Item 23a) (Type, Print)	excest Types					
_			HI. J. Africatela 300 west 9th Street. For	ederick, MD					
	Sta		NULL II X /IUIN THEOREM Theorem						
	Registra	ell:							

Modi	ian	Decedent's Name (First, Mid	Thomas	Thomas	Rober	tson			Date of Death Month	Day 26	Year 2005	3. Time of De
Exami	ical ner	4a. Facility Name (If not instituti			HODEL	4b. City, Town,	or Location of		Dly		ty of Death	10
		University of	Maryland	Medical	Center	Bal	timo	S		N	A	
Funeral Director		5. Social Security Number 301–50–6589	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 53	. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min. Ma	Date of Birth (Month, Day, ay 30,	^{Year)} 1952	9. Birthpi Coun Oh	lace (State or F (ry) LO
land		Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. Ci	ity, Town or Lo	ocation					10	0d. Inside City
Many -f sh	ţō	MD How	ard		Elkri	doe						1 🗆 Yes 2
r 28a	lrec	10e. Street and Number	<u> </u>		DIKLI	10f. Zip Code			10	g. Citizen of	What Coun	try?
th wit	a	5879 Chipwood Court 21075						USA				
r dea	Funeral Director	11. Marital Status		cedent Ever in U	J.S. 13.	Was Decedent of I	Hispanic Original	gin? (Specify	Yes or No-	14. Ra	ce - America	
s afte	by Fu	1 Never Married 2 Ma	arned 1 XYes If Yes, G	2 □ No iive		1□Yes XXNo			, 0.0.,	Speci	τ.	√hite
hour:	g pe	3 Widowed 4 Divorce		Dates:	16a Dana	d#- H1 O						
in 72 n "nai	Completed	(Specify only highest grade completed)			(Give	dent's Usual Occu kind of work done DO NOT use retire	durina most	t of working	16b. Kind of Business/Industry			
with iene. r than	mo	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4or 5+)			lift Ope	-		Warehouse			se
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinations in collification once.	Be C	17. Father's Name (First, Middle	e, Last)	-		- F		r's Name (Fi	rst, Middle, M			
uld be Jenta rked tic ev	To B	Lynn Robertson	n				Lu	cille	Agler			
sho and h		19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailir	ng Address (Street				City or Town	, State, Zip	Code)
and 2 salth in 27 I		Sandra R. Rob	ertson (Wi			Chipwoo		t, E11	kridge,	MD 2	1075	
mit. Pages 1 and 2 should be filed within 72 hours alt partment of Health and Mentai Hygiens Instrueit, or portant: if Item 27 is marked other than "natural", or y injury or other traumatic event, the Medical Examise.		20a. Method of Disposition 1 X Burial 2 □ Cremation	2 Deamwel from	20b. i	Place of Dispo	sition (Name of matory or other pla	ice)	Date	2	0c. Location	- City or Tov	wn, State
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Departr Departr mports any inj		21. Signature of Funeral Service	e Ligensee		22	Name and Addre Hardest	ess of Facility	ral Ho	ome P	Δ		
205 20		177 %	9			12 Ridge					MD 214	01
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a C;	oach line.	5	er the mode of dyi	ng, such as	cardiac or res	spiratory arres			
/Medical Examiner	cal Examiner	disease or condition	a. C: Due to	cchos:	Abus		ng, such as a	cardiac or re	spiratory arre			Interval Between
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ttending Physician: The law requires that the death certificate be executed death. Stort: After this certificate has been signed by the attending physician and in the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immission cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	consequence of pregnation of Injury nth, Day Year)	quence of): Abya quence of): ancy al death 5 [death 5	DEctopic pregnance Other (specify) It 3 DOA 28c. Injur Wor M 1	y ven in Part I. 26. Place ner: 4 □ Nur	of Death (Chrsing Home 28d.	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2 eck only one 5 Residen Describe how	23d. Da Mo Lecco use con 2 No 24b. 24b. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ate of deliver onth [] tribute to the 3 □ Proba Were autopprior to comdeath? 1 □ Yes 2 her (Specify) red	y y Day Year e cause of death bly 4 Clunkr sy findings avail pletion of cause
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or Attending Physician: The law requires that the death certificate be executed the redeath. If death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit or by the funeral director.	Certification; To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if a.y. leading to immisdiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	constant a consect of constant at time of consumer of pregnations at time of consumer of linguistration of linguistratio	ancy al death 5 sulting in the un	DEctopic pregnance Other (specify) anderlying cause give t 3 DOA 28c. Injury Wor M 1 Deet, factory, office	yen in Part I. 26. Place ner: 4 □ Nur ry at rk? Yes 2 □ N me, date and	of Death (Chrising Home 28d.	23e. Did toba 1 Yes 24a. Was an autopsy perform one of the call of the call of the call the time, dat	23d. Da Mo 22db. 24b. 24b. 24b. 24b. 25d Other 25d	tribute to the 3 Proba Were autop prior to comdeath? 1 Yes 2 ner (Specify) red per or Rural anner as sta	y Y Day Year e cause of death bly 4 Clunkr sy findings avar pletion of cause Clunk Route Number, ted. the cause(s)
Hospital or Attending Physician: The law requires that the death certificate be executed 14 hours after death. Funeral Director: After this certificate has been signed by the attending physician and 11 piector. After this certificate has been signed by the attending physician and 11 piector. page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if a.y. leading to immisdiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	constant a consequence of pregnabint at time of chown death but not resulted to find the constant at time of chown death but not resulted to find the constant at time of chown death but not resulted to find the constant at time of chown death but not resulted to find the constant at time of chown death but not resulted to find the constant at time of the constant	ancy al death 5 sulting in the un	DEctopic pregnance of the control of	y ven in Part I. 26. Place ner: 4 \(\text{Nur} \) Nur y at rk? Yes 2 \(\text{Nu} \) me, date and pinion, death se number	of Death (Chrising Home 28d.	23e. Did toba 1 Yes 24a. Was an autopsy performed to the cauth of the cauth of the cauth of the time, dat	23d. Date signe	tribute to the 3 Proba Were autopprior to comdeath? 1 Yes 2 Der (Specify) red anner as sta and due to the discount of the component of the co	y Y Day Yea e cause of deat bly 4 Clunk sy findings ava pletion of caus Clunk Route Number, ted. the cause(s)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** July 25, 2005 4:00 P M Rubino E. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ocean City Worcester 206 Constellation House South If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day Year)

Months Days Hours Min. (Month Day Year) 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Washington, DC Months 1 □ M 2 🛛 F 72 Director 577-44-7781 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d, Inside City Limits 10a State 10h County itam 27 is markad other than "natural", or Itams 23a or 28a-1 show other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Director Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 1 21401 USA 905 Bridgeport Court death v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Tyes 28 No Specify: Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Mailing Service Office Administrator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carr Winifred ဂ္ Thomas Patrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 t of Health a Thomas Rubino - Son 2806 Tellier Ct., Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State 0 Department of Important: If any injury or once. Resurrection Cemetery 7/29/2005 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
George P. Kalas Funeral Home, P.A.
2973 Solomons Island Rd., Edgewater, MD 21037 21. Signature of ral Service Licenses (0 23a. Part1. Enfet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or read a failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5ema disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Arteri OSCIEVOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and is the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 Yes 2□ No 1 ☐ Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 V ther (Specify) Room 1 Yes 2 No 2 this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To tha 29d. Date signed (Month, Day, Year) nd title of certifier 29c. License number 29b. Signature mi 6/0 30. Name and address of person who cop pleted cause of death (Item 23a) (Type, Print) 38 Deitens Howard 32. Refistrar's Signature 31. Date filed (Month, Day State JUL 2 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Pamela Sue Starkey м 2005 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Washington 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 4—14—19 11 **Funeral** 9. Birthplace (State or Foreign Months 215-90-5372 1 ☐ M 2 🔯 F 34 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ral', or Items 23a or 28a-f shov Erantrer must be notified at Director Maryland Washington 1 ☐ Yes 2 ☑ No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11557 Robinwood Dr Apt 4 21742 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2√ No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 Specify. White 1 Yes 2 No 3 Widowed 4 Divorced natural Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd Mental marked o Michael D. Starkey 2 Karen Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Michael D. Starkey/Father 523 Salem Ave Hagerstown MD 21740 20a. Method of Disposition

WBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ~ <u>=</u> Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 8-12-05 Hagerstown MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRest Haven Funeral Chapel 5 Merel 1601 Pennsylvania AVe Hagerstown MD 21742 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one date ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medicai use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 3 Ectopic pregnancy for Month 4☐Pregnant at time of death 5 Other (specify) the P.O. 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, q Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 2 No 1 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 TNo Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Hospital or Attend 24 hours after death Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 9 29c. License number dause of death (Item 23a) (Type, Print) Pagistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day William Arthur Sillery Augus 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 19661 Marigold Drive Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/14/1934 Birthplace (State or Foreign Country) **Funeral** Months 1**√** M 2□ F Director 140-24-3723 70 NJUsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2√ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19661 Marigold Drive 21742 US fited within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant 0i117. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Surname) Harry (unk) Sillery Mabel (unk) Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 311 Justice Dr., Carneys Point, NJ 08069 David A. Sillery / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 08/09/2005 Smithsburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home Street, Hagerstown, MD 21740 Potomac 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NO 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical the be detached for use as IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has 2 X No 2 No 1 Yes 1 Tyes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Other: Certification: To 1 🗀 Yes 2 ER/Outpatient 3□ DOA 4 🗌 Nursing Home Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation nours after death neral Director: / filled in by the fi 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number Date signed (Month, Day, Year) 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUG 10 31. Date filed (Month, strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 6.49 AM DASCHA SHEIKH-YUSUF GILLIARD AUGUST 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba The Johns Hopkins 100 Saftimere Cit If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State (Month, Day, Year) 1979 England 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days Director 217-15-3049 26 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rsi', or Items 23s or 28a-f show Examinar must be notified at Director Maryland 1 ☐ Yes XXNo Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12171 Ell Lane, Apt. 74 20602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atternent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No **Black** þ Specify: 3 Widowed 4 Divorced natursi Completed 7 is marked other than "natu treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David J. Thorpe Eva E. Louisy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Liban A. Sheikh-Yusuf - Husband 12171 Ell Lane, Apt. 74, Waldorf, MD 20602 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. Maryland Veterans' Cem 8-10-05 Cheltenham, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P. O. Box 156 M00053 Waldorf, MD 20604-0156 10. Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DIFFUSE CEREBRAL EDEMA 10 DAYS /Medical Due to (or as a consequence of): **Examiner** DIABETIC KETOACIDOSIS 12 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certiticate be executed DIABETES 10 YEARS physician and s the burial-trans MELLITUS that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 0 Month Day Year Pregnant at time of death 5 Other (specify) P.O. ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has be irector, page 2 s autopsy performed 2XNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical director 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending Injury 1.XNatural 5 Pending death. 1 Yes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO RES AUGUST, 4, 2005 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAVIA COSGROVE, JOHNS HOPKINS HOSPITAL, GOD NORTH WOLFE STREET, BALTIMORE, MARYLAND 21287 MP

State Registrar AUG 0 8 2005

32. Resistrar's Signature

		Please Type or Print in Black I State of Maryland / De	partment of	Health and N	Mental Hygi	ene				
		1 - State Registrar C	ertificate of	Death	2. Date of Death	g. No2 () () 5	2 7 3 2 2 3. Time of Death			
• Physi	iciar dica	HAZEL ELIZABETH SCHOTTA			AUGUST	^D 2 ^y , 2005	9:55 P			
Exan		Aa. Facility Name (If not institution, give street and number) CARROLL HOSPITAL CENTER	WESTMI			4c. County of Deat CARROLL				
Funera Directo		5. Social Security Number 215-07-3122 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 98 Yrs.	Months Days		8. Date of Birth Month Day, AUGUST	9. Birt 5, 1906 M	nplace (Stete or Foreign ARYLAND			
Maryland Area Area Maryland Maryland Maryland	tota	10a. State 10b. County 10c. City, Town or MARYLAND CARROLL WESTM.		10d. Inside City Limits 12 ves 2 □ No						
with the 3c or 28	Directo	10e. Street and Number 205 ST. MARK WAY APT. 410	10f. Zip Code 21	158	10	g. Citizen of What Co UNITED S				
INCL A I A 19-0030 be filed within 72 hours after death with the Maryland and Hygiene. and Hygiene. and other than "natural", or Items 23c or 28e-f show event, it a Madical Example or must be rediffed an	hy Financial	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes No	3. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecifý Yes or No- o Rican, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: WHTTE.				
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0 = 0 5	9	17. Father's Name (First, Middle, Last)	laiden Sumame)							
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Dalitimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny injury or other traumatic e		X Burial 2 Cremation 3 Removal from State PARKWOOL	sposition (Name of crematory or other place) D CEMETER	Y 8/05,		BALTIMORE,				
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UNISION OF VITA To the Hospital or Attending Physician: While 24 hours after death To the Funerel Director: After this certific completely filled in by the funeral director.	- 15		e of 28c. Inj		28d. Describe hov		.,,,			
UIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Cortification	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	eet and Number or Ru State)	ral Route Number,						
Hospil 24 hour Funer etely fills	locipal	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To the within To the compl	A.	29b. Signature and title of certifier		nse number		d. Date signed (Month	, Day, Year)			
WIS		30. Name and address of person who completed cause of death (Item 23a) (Typ. NIBHA KOHLI 686-C POOLE F	pe, Print)	ESTMINS			21157			
	State	31. Date filed (Month, Day, Year) 32. Regularia's Signature	how. V.	O CIPITINO		1.V				
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month narles /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death enthelds noderic Derrok If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Mar. 31 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 208-01-3059 90 Director 1915 Pennsylvania Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Maryland Frederick 1X Yes 2 No Director Woodsboro 10e. Street and Number 10f. Zip Code permit. Pages 1 end 2 should be filed within 72 hours efter death with t. Department of Health and Mental Hygiene.
Importent: if Item 27 is marked other than "natural", or Iteme 23a or 2, any njury or other traumatic event, than Medical Expenses 200.2. 10g. Citizen of What Country? 201 S. Main St. 21798 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Nidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) draftsman steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michael Shuty Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Shuty/ nephew 5518 Ohio St. Pittsburgh, PA 15225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State St. Mary's Cemetery 8/9/2005 Pittsburgh, PA ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tue of Frineral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home amarine 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician POXEN disease or condition resulting in death) /Medical Due to (or as a equence of): **Examiner** the Ciny Directo Sequentially list conditions, Examiner any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospitel or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): signed by the attending physicien I be detached for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4∏Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed? 1 ☐ Yes 2 **1**0 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 15 ing 1 ☐ Yes 2 ☐ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:30 \mathbf{P} M Martha Marie Suter 31 July 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Pikesville 600 McHenry Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖫 F 64 214-38-7854 Director 11, 1940 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d Inside City Limits or 28e-f ehow other treumatic event, the Medical Eraminer must be notified at Pikesville 1 ☐ Yes 2 X No Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 United States 600 McHenry Road or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🖾 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Phillip Arthur Cugle Mamie Ardelia Derfilinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 600 McHenry Road Pikesville, MD Francis Pat Suter, Sr. Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ò permit. Page Department of Important: If any injury or once. Charles Cemetery Aug. 4, 2005 Pikesville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory,
1212 W. Old Liberty Road Winfield, MD Tanue 21784 23a. Part 1 Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GIS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Physician/Medical Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Division of Vital Records. peq 1 🗌 Yes 2☐No 3☐ Probably 4 ☐Unknown the funeral director, page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1 ☐ Yes 2 No မ 5 Sesidence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Manner of Death Certification: Injury at Work? After Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Pate signed (Month, Day, Year) 12005 WJL 00 15 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Owings Mills. Kawaja (Month, Day, Year) 101 20 (rossRoads 31. Date filed (Month, Day, 32. Registrar's Signature State AUG 0 3 2005 blam & Spork Registrar

		1_ For State	State of Maryland	d / Depa	artment of H	lealth and N	nental Hyg	giene		27225
Physic	cian	1. Decedent's Name (First, Middle, Lasi)	Cei	rtificate of STEWA		2. Date of Dea Month	ath Day	005 Year	3. Time of Death 9 - 06 PM
/Med Exam Funera	lical iner	4a. Facility Name (If not institution, give The Johns A 5. Social Security Number 6. Se	OPKINS HOSPI X 7. Age (In yrs. Ia	st birthday)	4b. City, Town, o	or Location of Death A COLUMN STATE OF THE	8. Date of Birt (Month, Pa Jan. 15	4c. C	2001 County of Death	
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with the 3s or 28e	Il Director	10e. Street and Number 3612 Chandler Dr.			10f. Zip Code 2074	.4		_	en of What Cou	
If year I. C. I. C. C. C. C. C. C. C. C. C. C. C. C. C.	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 🖾 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	- 1	4. Race - Amer Black, White Specify: B1	, etc.
within 72 hours after inne. Then "natural; or Ita	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)		dent's Usual Occup kind of work done DO NOT use retire	pation during most of work d) e Clerk	ting		d of Business/I	ndustry
should be filed and Mental Hygi a marked other umatic evant, I	To Be C	17. Father's Name (First, Middle, Last) Paul Stewart					leaver			
t and 2 stream 27 is		19a. Informant's Name/Relationship (T. Mary Stewart / Mo 20a. Method of Disposition	other	1400		Dr. Eliz		wn, K		701
Datemit. Pages Dep-riment of I Importent: If its any injury or of	<u>.</u>	1 Burial 2 Cremation 3 1 1 Donation 5 Other (Specify, 21. Signature of Funeral Service Liceo	Eliz	zabetł	ntown		,2005 Funera			
Physiciar /Medica Examine purial-transit	1	23a. Pa . Enier the discusse, or compshock, or heart fail ine. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	Do not ent IN G ence of): A ence of):	SEPS iS		or respiratory ar			Approximate Interval Between Onset and Death G HOURS
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sign d be	b	Part II. Other significant conditions co	ntributing to death but not resul	ting in the u	nderlying cause giv	en in Part I.				the cause of death?
The lay ate has page 2	Completed						24a. Was autop perfor 1 Yes	sy med?		opsy findings available ompletion of cause of
tanding Physicath. tor: After this the funeral dil	ertification: To Be	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Time o Injury	f 28c. Injur Wor M 1	Yes 2□No	ome 5 ☐ Resid 28d. Describe h	ence 6	occurred	ify) ral Route Number,
pito ours era	O	4 Homicide determined 29a. Certifier 1 Certifying Phy	building, etc. (Specify) sician: To the best of my know	rledge, deati	h occurred at the tir	ne, date and place.	City or Tow	n, State)	nd manner as	stated
To the Hos within 24 ho To the Fun completely	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	ner: On the basis of examination and manner stated.	on and/or in	29c. Licens	e number		29d. Date	signed (Month	
-(21)		30. Name and address of person who co DAVID COSGROVE, JOI	ins horkins hosei	TAL, 6		wolfe stre	ET, BALT	IMOR	s, ms	21287
S Regis	tate strar	31. Date filed (Month, Day, Year) ALIC 0.8 2005	Registrar's Signatu	dra dra	de)					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yee **Physician** Stephens 952 hrs. Roy July 28, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs 8. Date of Birth 1938 (Month, Day, Year) Birthplace (State or Foreign Country) VIrgin 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Hours 1**X**M 2□ F Months Days Yrs. November 10, St. Thomas, Is. 580-03-2691 66 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 28e-f show other treumetic event. The Medical Examiner must be notified at 1X Yes 2 No Directo New York Westchester Tuckahoe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 100 Columbus Avenue; Apt. 7C 10707 United States Items 23e Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and 15 is marked other then "neturel", or Items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XYes 2 No 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Property Manager Real Estate 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Stephens Evelyn Pena 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10707 19a. Informant's Name/Relationship (Type, Print) 100 Columbus Avenue; Apt. 7C; Tuckahoe, New York Kecia Wilson (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aug. 13, 2005 U.S. Virgin Island 1 Burial 2 Cremation 3 Removal from State ō permit. Page Department of Importent: If eny injury or once. Western No:1 Cemetery; Charlotte Amaila; St. Thomas A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
W. Wesley Chavis III Funeral Services, er 1722 North Capitol Street, N.W.; Wash. D.C. 20002 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arthosclerotic Heart and Vessel Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner as the burial-transit The law requires that the death certificate be executed Cerebral Vascular Disease resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical esn. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year jo 5 Other (specify) 4☐Pregnant at time of death P.O. ed by the a 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ Records. 1 Yes 2X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X No 1 Yes 2 No certificate 1 ☐ Yes Division of Vital the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 | Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only onel and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0019924 30. Name and address of person who completed course of death (Item 23a) (Type, Print) Lawrence Oufiero, M.D.; 1500 Forest Glen Road; Silver Spring, Maryland 20910

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

AUG 0 8 2005

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		1	For State Registrar			,		tificate					Reg. No.		27227
Div		-	1. Decedent's Name (First, Middle	a, Last)								2. Date of Dea	ith Day	Year	3. Time of Death
	ysicia Aedica		Louis Anthony Shor									August			2:38 A M
Ex	amine	r	ta. Facility Name (If not institution Saint Mary's H			er)		4b. City, Leona		Location	of Death			County of Deat	
Fun	oral		5. Social Security Number	6. Sex		Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Birt	h		nplace (State or Foreign untry)
Direc	_		212-86-0224	1 🔀 M 2	P.O.F	42	Yrs.	Months	Days	Hours	Min.	(Month, Da) Jan 29,			yland
pud *	2.27	F	Usuel Residence of Decedent 10a. State 10b. County			10c. Cit	ty, Town or Lo	cation							10d, Inside City Limits
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the I	Hou	Director	Maryland St. Mar 10e. Street and Number	ys		Meci	Idli1CSV1	10f. Zip	Code				10g. Citi	zen of What Co	untry?
th with	ed la	<u> </u>	28535 Flora Corner	Road					20659				U.	.S.A.	
r dea	1	Funeral	11. Marital Status	Ar	med Force		.S. 13.	Was Deced	ient of Hi	spanic Or n, Mexica	igin? (Spe n, P uerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White	
rs afte	Ties I	D P	1 Never Married 2 Married 3 Widowed 4 Divorced	lf '	Yes 2 [Yes, Give ear or Date:			1 🗌 Yes	2 ∑ No	Specify.				Specify: Bla	ck
ation 4.14.1.2.00000 be filed within 72 hours after death with the Marylend that Hygiene. Ind other than "naturel", or Heme 23a or 28a-f show	9	- G	15. Deceden	t's Education			16a. Deced	ient's Usua	I Occupa	ition			16b. Ki	ind of Business/	Industry
thin 7	Med	Completed	(Specify only higher Elementary/Secondary (0-12)	1	<i>pietea)</i> ollege (1-40	or 5+)	life.	kind of wo DO NOT us	nk done d se retired,	uring mos)	st or work	ng			
led wi	a i		11	(4)			Auto	Mechan	nic	10 Math	ada Nama	/First Middle		Repair	
I be fill	*	g	17. Father's Name (First, Middle,									e (First, Middle,		,	
2 should be filed withing and Mental Hygiene. Is marked other than	matio	2	Robert Henry Short 19a. Informant's Name/Relations		rint)		19b. Mailir	ng Address	(Street a			zabeth Jo		r Town, State, 2	Tip Code)
nd 2 salth ar	ır trau		Floyd Alexander Sh	iort/Bro	ther		28535	Flora (Corne	r Rd.	Mech	anicsvill	e MI	20659	
Dattillole, Matyiat permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If item 27 Is marked	to t		20a. Method of Disposition 1XXBurial 2 ☐ Cremation			1 /	Place of Dispo cemetery, crer	sition (Nar	ne of			Date		ocation - City or	Town, State
Pag ment	lury o		4 Donation 5 Other (S	Specify)	ar noni ota		rles Memo							ardtown,M	
Dailing	eny in		21. Signature of Funeral Service	Licensee	1 ,) 22 D	. Name an	d Addres	s of Facili	Mat	tingley-Cown, Mary	ardi	ner Funer	al Home, P.A.,
		+	23a. Part1. Enter the disease, or	Complication	CACUA ns that caus	sed he deal	4								Approximate
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/Med	ical		disease or condition resulting in death)	a.Mu		e Inj									
Exami	,		Sequentially list conditions.	b											
p	Sit.	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	Due to (or	BRIDDIN BIRE	tuence of):								
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rtificat	as th		IF FEMALE:					-							
ath cer	or use	clan/Med	23b. Was decedent pregnant in the past 12 months?	1	Live birth	ne of pregna	al death 3	Ectopic p						23d. Date of del	very Day Year
he de	ped	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		☐ Pregnani ☐ Unknowr	t at time of d	death 5[Other (sp	ecify)						
thatt	deta	e P	Part II. Other significant conditi	ons contribut	ing to deat	h but not res	sulting in the u	nderlying c	ause give	n in Part	1.	23e. Did to	bacco u	use contribute to	the cause of death?
quires 1 quires 1 on signe	nld be											10	'es 2	□No 3□Pr	obabiy 4 🔏 Unknown
law req	2 sho	plet										24a. Was		24b. Were au	topsy findings available completion of cause of
The The	eged	Completed										perfo 1 D Yes	rmed?	death?	2 🗆 No
VICAL ician: 1 certificet	ector	Re	25. Was case referred to medica examiner?	il Hospit	al:				Othe			h (Check only o			
Phys 2	aral di	0	1 Yes 2 No 27. Manner of Death		1 ☐ Inpa a Date of I (Month,		2Fin Time o		8c. Injury Work	at 4□N	ursing Ho	me 5 Residente Participation Participation Residente P	ience now injur	6 □Other (Spe	n struck by
VISIOII Attending ar death. ector: Afte	e fune	Certification:	1 Natural 5 Pendir 2 Accident investi		3/13/0		2:01			c? Yes 2 √x	No	vehic		destriai	n struck by
r Atte	by th	1110	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		e. Place of building,	Injury - At h	iome, farm, str	eet, factor	, office					2349 B	ral Route Number, Redds Creek Re
urs aff	lled in				Roady	_						Clemer	its,	Maryla	nd
DIVISION OF VICE INCOMES, F.O. BOX 00 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys.	etely f	Medical		Examiner: (s of examina								and manner as place, and due	
o the	omple	Ş Z	29b. Signature and title of certifie			Stato d.		290	c. License	number			29d. Da	te signed (Monti	h, Day, Year)
F > F	,		Theode.	U.	16, g	in	رهي	(OCME				Δ11011	st 13,	2005
			30. Name and address of person			of death (Ite	т 23а) (Туре,		تلتابي	•	-		പട്വ	ин 1119 -	
			THE MORE 31. Date filed (Month, Day, Year,		1	istrar's Sign	atura	111	Penn	Stre	et,	Baltimo	re,	Marylan	d 21201
Re	Stat gistra		31. Date filed (MORRA, Day, 19a7,	-	/SZ. Heg	iouai s Sign	acure .		,						
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DHMH 17 Rev 1/2001

ORIGINAL

			1 State	partment of Health and Mental Hygiene ertificate of Death	3.6
3.	98		Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death 2. Date of Death 2. Date of Death 2. Date of Death 3. Dat) () Death
	Physicia	_		Month Day Year	М
	/Medic		Joseph Paul Swailes 4a. Facility Name (If not institution, give street and number)	4b. City. Town, or Location of Death 08 07 2005 9:00 4c. County of Death	_a
1	Examin	er		Lexington Park St. Mary's	
		175	Bayside Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.	avi If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or	Foreign
	Funeral Director		577-40-6650 1⊠M 2□F 79 Yrs	Months Days Hours Min. (Month, Day, Year) Country) 10-20-1925 Marvland	
ė _v .			Usual Residence of Decedent		
	rylan how		10a. State 10b. County 10c. City, Town or	Location 10d. Inside City 1 ☐ Yes 2	
	e Ma	cto	Maryland St. Mary's Leonar	cdtown	
	를 2 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Dire	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?	
	ath w	Funeral Director	41495 Connelly Street	20650 United States	
	er de	nue		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
36	s afte	by F	1 ★ Never Married 2 Married 1 ★ Yes 2 No 1945— If Yes, Give 3 Widowed 4 Divorced Year or Dates: 1947	1 ☐ Yes 2ॼ No Specify: Specify: Black	
21215-0036	within 72 hours after death with the Maryland ene. Han "natural", or itame 23a or 28a-f show 'ta Medical Examinar must be notified at		15 Decedent's Education 16a De	peedent's Usual Occupation 16b. Kind of Business/Industry	
5	in 72 in " r	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of working e. DO NOT use retired)	
12	thar than	E o	Elementary/Secondary (0-12) College (1-4or 5+)	ecurity U.S. Army	
b	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural; or itame 23a or 28a-f show event, the Mardical Examinar must be notified at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)	
an	Mental Mental arked o	To B	George Swailes	Emma Young	
2	S E E		19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	12 a		Cheryl Nelson/Niece 419	973 Satchel Paige Way, Hollywood, MD 20636	
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	sposition (Name of Date 20c. Location - City or Town, State crematory or other place)	
Ĕ	permit. Pages Department of I Important: If it any injury or o			Memorial Gar 8-11-2005 Leonardtown, MD	
ati	partriports		21. Signature of Funeral Service Lipensyle	22. Name and Address of Facility Brinsfield Funeral Home, P	.A.
m	89889		Edward N. Brinsfield, Jr. M00052	22955 Hollywood Road, Leonardtown, MD 2065	0
	Pnysic an /Medical Examiner	iner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	along Facture along Facture The Heart Facture Of Standard And December 1988 Of Standard A	
Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and cage 2 should be detached for use as the burial transit	n/Medical Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death	23d. Date of delivery	
o	at the death by the atte tached for	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	3 Ectopic pregnancy 5 Other (specify) Month Day Ye	ear
S, P	res tha igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the		
of Vital Records,	w requir been si should I	Completed		1 Yes 2 No 3 Probably 4 Pur	KNOWII
ပို	e law r has be	pie	Jeavers (24a. Was an autopsy findings a prior to completion of ca	variable use of
<u> </u>		Son		performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No	
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
<u>}</u>	Physician: r this certific rat director,	ဥ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		
		0	27. Manner of Death 1	ry Work?	
Sio	vttendii death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be Replace of Injury At home farm	M 1 Yes 2 No	
Division	or At litter d Direct in by	Certification:	4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office 28f. Location (Street and Number or Rural Route Numb City or Town, State)	er,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune		29a. Certifier 1 Certifying Physician: To the best of my knowledge, of	leath occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	e Ho	Medical		or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
	withir To th	M	29b. Signature and title of setifier	29c. License number 29d. Date signed (Month, Day, Year)	
	Je .		Jomal Lorbos A	1 506419 8-8-05	
	N. Y		30. Name and address of person who completed cause of death (Item 23a) (Ty	rpe, Print)	
_			James P. Jarboe, 24035 Three Not	cch Road, Hollywood, MD 20636	
	Sta Regist	ate rar	31. Date filed (Month, Da), Year) 32. Registrate Signature AUG 1 0 2005	1. Such	

			1 - For State Registrar	State of Ma	aryland		artmer <i>rtificat</i>			and M	•	giene	0 0 0	27329
	Physici		Decedent's Name (First, Middle, La Ernest LeRoy Sr	•							2. Date of De Month		y Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, given				4b. City,	Town, or	Location of	of Death	Aug	3 4c	2005 County of Dea	
25	×	7	Corsica Hills Nu	rsing Home				Cent	revi	l1e		C	ueen Ar	nne
	Funeral	- 28	Social Security Number 6.5	Sex 7. Age	e (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	ay, Year)	C	rthplace (State or Foreign country)
	Director		194-28-8755 Usual Residence of Decedent	6	57	Yrs.					12/20/	1937	Peni	nsylvania
	yland		10a. State 10b. County	<u> </u>		, Town or Lo	cation							10d. Inside City Limits
	Ba-f el	ctor	MD Carolin	ne	Ma	rydel 								1 ☐ Yes X ☐ No
	vith th	Dire	10e. Street and Number				10f. Zig						tizen of What C	ountry?
	eath v	eral	17300 Cool Spring	Road 12. Was Decedent 8	Ever in II S	12.1	Mas Dass	2164		nin 2 /Cno	aity Von ar Ne	US	SA 14. Race - Am	origan Indian
9	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show eny injury or other traumatic event, I'm Medical Exercitest must be notified at once.	Funeral Director	11. Marital Status 1 ☐ Never Married 2【 Married	Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates: 1			vvas Dece If Yes, spe 1 ☐ Yes		spanic On n, Mexican Specify:	gin ? (Spe i, Puerto f	cify Yes or No Rican, etc.)	,	Black, Whi	
8	ural',	d by	3 Widowed 4 Divorced		955-									nite
5	in 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)		16a. Dece (Give life. I		rk done d	uring mos	t of workin	ng .	16b. K	and of Business	s/industry
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<u> </u>	e file al Hyg rothe vent,	Bec	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle			
<u>ylaı</u>	should be nd Mental markad o umatic eve	10	Alfred Snow								Bittne			
ā	12 sho		19a. Informant's Name/Relationship (Dorothy Snow / with			19b. Mailir 17300					l Route Numb	er, City o	or Town, State,	Zip Code)
e)	1 and Health am 27 ther to		20a. Method of Disposition	rie	20b. Pla						ete	20c Lo	ocation - City or	r Town Slate
ğ	Peges nent of I int: If Its iry or o		1 ☐ Burial 2 🌠 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			ace of Dispo				3/4/2				
	permit. Pege Department of Important: If eny injury or once.		21. Signature of Fyneral Service Lice		Cires	sapeak 22							ester, N	in Funeral
ñ	Depa fmpo eny ir		Ham C	Klin							-		o, MD 2	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ent	er the mod	le of dying	, such as	cardiac or	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a		Bw	ial	San	lown	dec	JMW	tean		Onset and Death
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	entific ding p	/Mec	IF FEMALE:	220 If was automa			-							
Вох	death certifica attending ph I for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3□	Ectopic pi						23d. Date of de Month	livery Day Year
Р. О.	by the de trached	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	-	a 5_	J Other (a)	ocny)						
	The law requires thet the tee has been signed by thoage 2 should be detached.	by Pi	Part II. Other significant conditions	contributing to death bu	it not resul	lting in the ur	nderlying c	ause give	n in Part I.		23e. Did I	obacco u	use contribute t	o the cause of death?
Vital Records,	w require been sig should b										10	Yes 2	□ N₀ 3□P	robably 4 Unknown
ပို	has be	Completed									24a. Was	an	24b. Were a	utopsy findings available completion of cause of
		Соп									perfo	med? 2∕⊡No	death?	
<u> </u>	ysician: The is certificate his director, page	Be	25. Was case referred to medical examiner?	Hospital:				Otho	-		(Check only o			
5	ਦੂ ਵੇਲ	2:	1 Yes 2 No	1 ☐ Inpatie		R/Outpation 28b. Time of			NU		e 5 Resident		6 ☐Other (Spe	ecify)
0	nding ith. : After e funer	tlor	1 Natural 5 Pending 2 Accident investigatio	(Month, Day	Year)	Injury	м	8c. Injury Work 1 🗆 Y	? ′es 2.⊟h			now injul	y cacamoa	
Division of	2 2 2	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At hon	ne, farm, str	eet, factory	, office		2	8f. Location (S			ural Route Number,
	pital ours ours neral filled		29a. Certifier 1 Certifying Pl	nysician: To the best of	of my know	rledge, death	occurred	at the time	e. date and	d place, a	nd due to the	cause(s)	and manner a	s stated
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Examone)	miner: On the basis of and manner sta	examination	on and/or inv	estigation	, in my op	inion, deat	h occurre	d at the time,	date and	place, and due	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and Title of certifier					. License		,			te signed (Mont	
			1874	Court			1	73	203	6		81	3/100:	
			30. Name and address of person ho Gary J. Sprouse,					heet	er N	/D 21	619			
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra			ا وصد) IIGS L		ш ZI	.019			
			AUG - 4 20	INS Make	20 6		THE PERSON							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** August 2, Edward V. Sullivan. Sr. 3:30 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Morningside House of Friendship Hanover Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5-25-1914 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** M 2□ F Months Director 050-10-4580 Connecticut Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County item 27 ie markad other then "natural", or itams 23a or 28a-f show other traumatic event. Its Modical Exacultar i ust be notified at 1 ☐ Yes 2 📉 o Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1005 Mastline Dr. 21401 USA Completed by Funeral 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours aftar of and Mental Hygiene. Ie markad othar than "natural", or itar 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Insurance 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Joseph Sullivan 2 Adelaide Limbacher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Pages 1 and 2 sh Department of Health and Important: If Item 27 ie m any injury or other traum <u>2005</u>9. Kathleen V. Rainville/Daughter 1005 Mastline Dr., Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 8-8-05 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Senile DenenTra Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and the for use as the burial-transit The law requires that the death certificate be axacuted Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 TYes 2 **3**(10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy Yes Hospital or Attending Physician:
 24 hours after death.
 Runaral Director: After this certifice. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 200 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗆 Yes ther (Specify) SONE flours 0 4 Nursing Home 5 Residence 6 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To tha the 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 achaTRd Glen Burne MP 21061 -80 47 (5006 JTY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** Renate Shmer1 8:00 pM Ju1v 29 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 K F 71 Director 10, 1933 East Prussia 217-40-1110 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XXVo Director MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20724 or itams 23a 237 Marganza South USA death 1 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or itar □Yes 2XXNo Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White Specify: 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Hebrew School 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Gerda Levin 0 Jacob Moses Meron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pagas 1 and 2 si ment of Health an ant: If item 27 is r Shulem Shmerl (Husband) 237 Marganza South, Laurel, MD 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. *4 □ Donation 5 □ Other (Specify) 8-3-2005 Metro Crematory Baltimore, MD 21. Signature of Funeral Service 22. Name and Address of Facility
Hardesty Funeral Home, P.A 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure **Physician** /Medical Due to (or as a consequence of): Examiner Ruptured infarcted hiatal hernia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav 4☐Pregnant at time of death 5 Other (specify) the a detachad 9 Unknown 9 Unknown baan signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No ours after death.

Neral Director: After this certificatile in by the funeral director. or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Inpatient 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 1 ☑Natural 28b. Time of Injury Date of Injury (Month, Day Year) 28c. 28d. Describe how injury occurred Certification: Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10061890 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Anuradha Dahiya 31. Date filed (Month istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U () 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST **Physician** 2005 12:45 AM LORAINE DELORES WASHINGTON TIBBS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES 13121 RIVERSIDE ROAD NANJEMOY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, JUNE 2, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 1 ☐ M 2 🙀 F MARYLAND 74 Yrs 1931 Director 214-58-0993 Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If itam 27 is marked othar than "natural", or Items 23s or 28e-f show any injury or other traumatic avant, "the Medical Examinat must be notified at once." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director MARYLAND CHARLES NANJEMOY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20662 UNITED STATES 13121 RIVERSIDE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: Specify: þ BLACK 3X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) lementary/Secondary (0-12) College (1-4or 5+) **CLEANING INDUSTRY** CUSTODIAN 7TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LESSIE IRENE CRAIG WASHINGTON JOSEPH WASHINGTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 311 WINSLOW ROAD, OXON HILL, MARYLAND 20745 NELLIE GREER / DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State OAK GROVE CHURCH CEM. AUGUST 9, 2005 GRAYTON, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Strature of Fundral Price Scree LYVIA C. THORNTON JOHNSON THORNION FUNERAL HOME, P.A. 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 MD0583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has 2 🗌 No 1 ☐ Yes 2 ☑ No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 27. Mann Death completely filled in by the luneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Matural 5 Pending investigation 2 🗌 No 1 Tyes 2 Accident Diractor 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 4 Momicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)0021031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Michael

31. Date filed (Month, Day, Year)

Leatherwood

AUG 0 8 2005

32. Registrar's Signature

12070 Old Line Center, Waldorf, MD 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year Virginia C. Tobin 2005 August 6 5:30p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖺 F Months Days Hours Yrs. 82 Director 024-16-7568 12,1923 Connecticut Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 1 No 28a-f Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 713 Midway Avenue Apt. 112 Funeral 21771 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. If item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **∂** If Yes, Give Year or Dates: Specify: 3 XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold S. Corey Sr. Irene Maria Bates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 is Department of Health ar Important: If item 27 is any injury or other trau once. Debra Firth Eisel/Daughter 24001 Preakness Drive, Damascus, Maryland 20872 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery8/11/2005 Silver Spring, Maryland 21. Signature of Funeral Service Lin 22. Name and Address of Facility L. Molesworth P. A. Funeral Home 1 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mo Physician ans /Medical Due to (or as a donsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760. Physician/Medical the IF FEMALE: esn nse If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the 9□ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 No certificate 2 🗆 No 1 Yes 1 Yes Division of Vital director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Dimpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Injury 5 Pending after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Discompletely filled in 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D26499 August 8, 2005

DHMH 17 Rev 1/2001

State

Registrar

5

strar's Signature

#4_Culwell Drive, Mt. Airy, Maryland 21771

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald E. Miller, MD

AUG 0 9 2005

31. Date filed (Month, Day, Year)

		_ FOI	artment of Health and M <i>rtificate of Death</i>	Tental Hyglen Reg. N		221.
	4	Decedent's Name (First, Middle, Last)		2. Date of Death Month D	ay Year	ime of Seath
Physic /Medi	cal	Mildred Ruth Tate 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August 6,	2005 05	5:30 ^{Рм}
Exami	ner	Solomons Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Solomons If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Calvert Count	
Funeral Director		218-28-0051 1□ M 2☒ F 72 Yrs. Usual Residence of Decedent	Months Days Hours Min.	November 9,		
aryland •how	or	10a. State 10b. County 10c. City, Town or L				side City Limits ☐Yes 2 X No
the M	Director	Maryland St. Mary's Leonard 10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?	
h with 23a or	ai Di	44153 Woodmont Drive	20650	Uni	ited States	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examinational by notilling an optice.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Ind Black, White, etc. Specify: White	ian,
ad within 72 hours aff giene. er then "natural", or i, the Medical Exerti	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing	Kind of Business/Industry	
Hygier ther t	Ö	12 Offi 17. Father's Name (First, Middle, Last)	ce Assistant 18. Mother's Nam	e (First, Middle, Maide	J.S. Governme en Sumame)	ent
ild be illental iked o	To Be	Claude Shupe	Sarah	G]	lasco	
shou and M	-		ing Address (Street and Number or Rur	al Route Number, City	or Town, State, Zip Code,)
and and tealth m 27 her tr	1		3 Woodmont Dr., Le		, MD 20650 Location - City or Town, Si	tate
mit. Pages 1 and 2 should be file partment of Health and Mental by portant: If Item 27 le marked oth pijury or other traumatic event en grijury or other traumatic event grijury event grijury		1 Burial 2 M Cremation 3 Hemoval from State	osition (Name of ematory or other place) tan Crematory 8, 2	ust	exandria, VA	iaic .
permit. Departr Importe eny inju		21. Signature of Funeral Service Licensee 2 Muchael Yuren Handen	2. Name and Address of Facility Mattingley-Gardiner F P.o. Box 270, Leonard			
Physician	2	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each one. Immediate Cause (Final	nter the mode of dying, such as cardiac	or respiratory arrest,	Inten	oximate val Between et and Death
/Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	8			1
ficate be executed physicien and its the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
ath certif attending for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
det det	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		ouse controute to the cau	se of death?
The ate h page	Completed			24a. Was an autopsy performed?	24b. Were autopsy fin prior to completic death?	on of cause of
Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Other	th (Check only one) ome 5 - Residence	6 Cother (Specify)	
Attending Physic death. ector: After this by the funeral di	 -	27. Mapper of Death 27. Mapper of Death Natural 5 Pending (Month, Day Year) 2 Accident Investigation		28d. Describe how in		
5 \$ # \$ €	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Rout ate)	te Number,
To the Hospitel within 24 hours a To the Funerel formpletely filled	Medical (29a. Certifier (Check only one) 1 Sertifying Physician: To the best of my knowledge, deal call Examiner: On the basis of examination and/or and manner stated.				ause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier M.D.	29c. License number 19427	29d. C	Date signed (Month, Day)	(ear)
41		30. Name and address of person who completed cause of death (litem 23a) (Type IT) WAR MUNSHI, M. J. 100	HOSP RD. PR	MARY	REDERICK,	678
S Regis	tate trar	31. Date filed (Month, Day, Year) AUG 0 8 2005				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1:40 Agnes Marie Taylor August 10, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Dealh 4b. City. Town, or Location of Death Examiner St. Mary's Nursing Home Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs. Nov 5, Director 100 1904 Maryland 577-38-8120 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show amy injury or other traumatic event, the Medical Expriner must be notified at once. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22680 Cedar Lane Ct. #2201 20650 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give ² Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White ģ Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Oliver McKay Blanche Gertrude Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Marie Tippett/Daughter 45395 Tippett Road, Hollywood, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) August 12,2005 Hollywood, Maryland St. John's Cemetery 22 Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licenses Ruch P. O. Box 270, Leonardtown, Maryland 20650 Wieters 23a. Part1. Enter the disease, or complications that baused the death on one enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bladd ex Cancer **Physician** /Medical Due to (or as a consequence of) Examiner Hema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Dale of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 McTunknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) eral Director: After thi 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifiei 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. A. D. Shah, Medical Arts Building, Leonardtown, Maryland 31. Date filed (Month, Dav. Year) 32. Registrar's Signature State AUG 1 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician CHARLES EDWARD VAUGHT, JR. 10:30 PM AUGUST 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov 7, 193 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∑**M 2□F 218-26-7212 73 Vrs Director Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 27 is marked other than "natural", or items 23a or 28e-1 show treumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Directo Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 Warren Street, Apt 9 21078 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 XYes 2 □ No
If Yes, Give
Year or Dates: 1950-54 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Cab Company 5 Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nd Mental 1 Charles Edward Vaught, St. Katherine Elizabeth Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda J. Vaught / wife 515 Warren Street, Apt 9, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. Berkley Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 8/8/05 Darlington, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lisa Scott Funeral Home, P.A. 552 Lewis Street, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform rmed? 2 No 1 Yes 25. Was case refer ed to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P Inpatient 2 ER/Outpatient 3 DOA 27. May er of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

siclan and burial-transit à Records. certificate Vital his Director: / within 24 hours a

To the Funerel C To the

Baltimore, Maryland 21215-0036

al Hygiene.

6 Cood not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) re and title of certifier

addres

29d. Late-signed (Month, Day, Year) L 61

of person who completed cause of death (Item 23a) (Type, Print)

2005

State Registrar

Medical

egistrar's Signat

			State of Maryland / Departm 1- State Amend Items 6,7, per FH, C846, C8/1190	ent of Health and Mental Hy 105dbl are of Death	ygiene Reg. Ng. 0.05 27337
	Physici	an	1. Decedent's Name (First, Middle, Last) Vinda L. Vauls	2. Date of D Month	Day Year 20'.55 M
	/Medio Examin			City, Town, or Location of Death	4c. County of Death
			SACRED HEART HOSPITAL	CUMBERLAND	ALLEGANY.
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 65 7. Age (In yrs. last birthday) Mon 1 M 2 F 65 Vrs.	nder 1 Year If Under 24 Hrs. 8. Date of 8 (Month, Days Hours Min. Jan.	9. Birthplace (State or Foreign Country) 23,1940 WV
	yland		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	88-1 s	Director	WV Mineral Keyser		1 X Yes 2 No
	with the	Dire		. Zip Code 26726	10g. Citizen of What Country? U.S.A.
36	n 72 hours atter death with the Maryland "natural", or items 23a or 28a-f show edical Examinat he notified at	by Funerai	1 Never Married 2 Married 1 Tyes 2s TaNo	ecedent of Hispanic Origin? (Specify Yes or N specify Cuban, Mexican, Puerto Rican, etc.) is 25th No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's	Usual Occupation f work done during most of working	16b. Kind of Business/Industry
21	c *_ @	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	T use retired)	Automated Packagin
	be filed withing Hygiene.		12th Mach	ine Operator 18. Mother's Name (First, Middle	
lan	o d stal	To Be	Robert F. Jackson	Sarah E.	
Maryland	nd 2 sh aith and 27 is rr r treurr			ress (Street and Number or Rural Route Num Gilmore Street,	
altimore,	of H of H f Iter		20a. Method of Disposition 1 □ Burial 2XC Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, crematory	(Name of Date or other place)	20c. Location - City or Town, State
tim	permit. Pages Department of h Importent: If Its any injury or of once.		`4 □Donation 5 □Other (Specify) Scarpelli	Crematory 8/16/05	Cresaptown, MD
Bal	permit. Par Departmen Importent: any injury		Hard Dean roperger Mar	e and Address of Facility Kwood Funeral Hom D. Box 912, Keyser	, WV 26726
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		10 dings
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900	law require as been si 2 should b	Completed	Stroke, Paroxysmal Atrial fibra	elation 24a. Wa	us an 24b. Were autopsy findings available opsy prior to completion of cause of
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ion	tending leath. tor: Atte the tun	atio	1 ☑ Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M	Work? 1 □ Yes 2 □ No	
Division	or Atter after de Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office 28f. Location City or T	(Street and Number or Rural Route Number, iown, State)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the tune.	Medicai Co	29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledge, death occu 2☐ Medical Examiner: On the basis of examination and/or investigation and manner stated.	ition, in my opinion, death occurred at the time	a, date and place, and due to the cause(s)
	othe ithin 2 othe omple	Mec	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
)	F > F 0		Mininfmaan, MD.	D-56207	August 12, 2005
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSAM SEMAAN MD SACRED (FEM	T HOSPITAL CLUM	1 berland MD 21502
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 9 2005		29d. Date signed (Month, Day, Year) August 12, 2005 buland MD 21502

05-05373 Kevi RJD

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n	Vodvarka	a _	For State	State of Maryland				nd Mental	Hygiene		
0	15.1.2		Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Jeath	2. Date	Reg. No.	005	2 7 2 2 0
F	Physicia /Medic		Kevin A. Voi	DVARKA				Aug	ust 8ay	2005 ear	2222P. M
	Examin		4a. Facility Name (If not institution, give s University Hospita	treet and number)		4b. City, Town, or Baltimor		Death	40.	Sounty of Deat	40re
7.	Funeral Director		ZZZ 10-1761	M 2□F 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date (Mont	of Birth h, Day, Year) 22, [9	1 1 Co	hplace (State or Foreign Juntry)
	show ad at	2	Usual Residence of Decedent 10a. State 10b. County Kent	11	Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28a-1	rect	10e Street and Number #		RTL	10f. Zip Code			10g. Citiz	zen of What Co	
	ath with	ra D		uss Road		1995				15A	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be multiped at	by Funeral Director	11. Marital Status 1 Marital Status 1 Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	Vas Decedent of Hi f Yes, specify Cuba □ Yes 2 1 No	spanic Origin n, Mexican, F Specify:	n? (Specify Yes Puerto Rican, eti		14. Race - Ame Black, Whit Specify: W	e, etc.
21215-0	i within 72 ho iene. r than "natui the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	lent's Usual Occupa kind of work done of DO NOT use retired	furing most o)	f working	16b. Kir	or CVC	le shop
and 2	buid be filed Mental Hygid arked other atic event,	To Be C	17. Father's Name (First, Middle, Last)	OVARKA		.,,,,,,,,,,		Name (First, M	-		
Maryland	d 2 should th and Mer ?7 is marke traumatic	ř	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street a	and Number o		lumber, City or	Town, State, 2	Zip Code) 1 9953
	00		20a. Method of Disposition 1 Ma Burial 2 Cremation 3 Re	20b. Pla	ce of Disponetery, cren	sition (Name of natory or other place	9)	Date	1	ation - City or	
Baltimore,	permit. Pag Department Important: I sny injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Sha	22	Name and Address		4 12,20	Brad		ST:
	40 E * 0		23a. Part1. Enter the disease, or complic	cations that caused the death.			J. such as ca			lover, L	E 19904 Approximate
)	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Multiple	in	sies					Interval Between Onset and Death
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9	ntificate ng phys s as the	Medic	IF FEMALE:								
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<u>α</u>	res that igned by be deta	Ď	Part II. Other significant conditions con	tributing to death but not result	ing in the ur	nderlying cause give	en in Part I.	23e.	(2	the cause of death?
ecords,	w requir been si should	Completed							Was an	24b. Were au	itopsy findings available
l Re	10	Somp						10	autopsy performed? Yes 2 No	prior to death?	completion of cause of 2 No
of Vital R	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		. all pos Cthe	\r.	f Death (Check			
	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury 2	8b. Time of	1 3L 00A	4	ing Home 5 28d. Desc	cribe how injury	occurred	1
Division	Attending or death.	catlo	1 □ Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	(Month, Day Year) 8-8-05	17:3	YM 10	res 2 No		Jh 3K	uck &	xed objects
Divi	ospital or Attendous after death hours after death uneral Director: ly filled in by the	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)		eet, ractory, office		330	Town, State)		iral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowler: On the basis of examination and manner stated.	edge, death	occurred at the tim	ne, date and pointion, death	place, and due to occurred at the	o the cause(s) time, date and	and manner as place, and due	stated. to the cause(s)
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			30. ran e and address of person who co	mpleted cause of th Item 2	23a) (Type,	Print) 111 Pe	enn St	reet. Ba	altimor	e Marvl	and 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re						
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Charles Joseph Valentino 4 2005 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 10€0kM 2 □ F 098-36-4122 58 July 12, 1947 New York Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at Annapolis 1 ☐ Yes 2 TNo Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code itams 23a or 21401 U.S.A. 543 Paw Paw Cove 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2¥2100 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 20X Married ŏ White Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: δ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be tiled within .
Department of Health and Mental Hygiene .
Important: If item 27 is marked other than "n any injury or other traumatic event, the Media once. College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Civil Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Valentino Alyce DeMarco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Valentino/wife 543 Paw Paw Cove Annapolis, Maryland 21401 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State akemont Mem. Gardens 8/8/2005 Davidsonville, MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Ser 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a rest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of Examiner the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death Check on one funeral director, 25. Was case referred to medical Other: Hospital: 1 Yes 2 No $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) After 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation death. 4 hours after death.

-uneral Director: A
ely tilled in by the fu 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely tilled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and file of certifier 0 0 on who completed cause of death (Item 23a) (Type&Print)

State Registrar 31. Date filed (Month, Day, Year)

AUG 0 5 2005

32. Refistrar's Signature

**Refiser & Apark

State of Maryland / Department of Health and Mental Hygiene

13.4						Certific	ale UI	Death		Reg. No.	75	2731.1
Dhysician	_	Decedent's Name (Firs	t, Middle, Las	t)					2. Date of De Month	eth Lay	Year	-3. Time of Deat
Physician /Medical	-	Mary			W	illiams				28 2005		8:40 PM
Examiner	4.0	Fecility Name (If not in	nstitution, give	street and number)				4b. City, Town, or	Location of Deatl	4c. Count	y of Death	
		Prince Geo	rge's	Hospital				Chever1	У	Princ	ce Geo	rge's
Funeral	5.	Social Security Number				ast birthday) If U	nder 1 Year		8. Date of Bir	18 1923		
Director	2	230-22-5270	11	□M 2121F 82	<u>></u>	Yrs.	llis Days	I louis Will	March	18 1923	Virg	ace (State or Fore try) inia
	Us	sual Residence of Dece	dent	1								
Piow		Da. State 10b.	County		10c. City	, Town or Location					10	d. Inside City Lim
Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show wither traumatic event, the Modical Exerviting must be notified at the Completed by Funeral Director		MD	Prince	George's	'	Springda]	.e					1 ∏ Yes 2 □
23a or 28a-f shoust be notified at	10	De. Street end Number					Zip Code	74		10g. Citizen of	What Count	try?
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r tems 23a diner must. Funeral	11	10024 01d 1. Marital Status	Ardwic	12. Was Decedent			20774		Specify Yes or No	U.S.A	ce - America	an Indian.
출출 원	1	1 ☐ Never Married 2	2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N		If Yes,	specify Cul	Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	Bla	ack, White, e	
by I		3⊠Widowed 4□D		If Yes, Give Year or Dates:	***	1 □ Ye	s 221 No	Specify:		Specia	^{fy:} Bla	ck
M P						16a Dandentia	Invel Once	ti		40h Kind -4 F		
Yours. Note than "nature It, the Medical Is Completed	L.	(Specify on!	Decedent's Edu <i>ly highest gr</i> ad	de com <i>pleted)</i>		16a. Decedent's	work done	pation a during most of wo ad)	rking	16b. Kind of E	susiness/ind	ustry
E E	١,	Elementary/Secondary	(0-12)	College (1-4or 5	i+)		r use reure	94)		D .		
S # 5		11th				Baker		1		Priva		
of other than event, the Manager Be Comp		7. Father's Name (First,							me (First, Middle,		•	
arkec atic		James	Coope	r				Dais	У	Coopei	<u>c</u>	
7 Is marke traumatic		9a. Informant's Name/R	elationship (T	ype, Print)		19b. Mailing Add	ress (Stree	t and Number or R	ural Route Numb	er, City or Town	, State, Zip	Code) 20774
27 l	F	Phillip Wi	lliams,	/Son		10024 0	ld Arc	lwick Ard	more Roa	d Sprin	ngdale	, Marvla
If item 2 or other	20	a. Method of Disposition	n		20b. Pl	ace of Disposition emetery, crematory			Date	20c. Location		
Department of near Important; If item 2 any injury or other 2000.		1 ☑ Burial 2 ☐ Crer							0.40.40			
rtan juri	-	4 □ Donation 5 □ C			Dal	e Memoria	ıl Par	ck ess of Facility J	8/9/05	Cheste	rfiel	d,Virgin
any ir	21	1. Signature of Funeral S	Service Licens	see /	11	22. Nam	<i>e e</i> na Adar	ess of Facility J	b. Jen	kins ru	neral	Home
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ysician Medical aminer	Im dis re	3a. Part1. Enter the dise shock, or heart failu nmediate Cause (Final isease or condition ssulting in death)		a. FATAL	CARD	YAC AX	RHYT				 	Approximate Interval Between Onset and Death
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Michael E. Wimer 05-5293 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	-	partment of t e <i>rtificate of</i>			jiene eg. №2 N ∩ 5	2721.1
16	*	W.	Decedent's Name (First, Middle, La.	st)				2. Date of Dea	th = 000	3. Time of Death
	Physicia /Medic		Michael	Edward	W	mer		August	5, 2005	7:28 P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of Deat	
			126 Sunhigh Dr			Thurmo			Frederick	
	Funeral Director		5. Social Security Number 6. S 211-58-1767	ex 7. Age M 2□F	38 Yrs.	Months Days		8. Date of Birth (Month, Day Mar. 30		nplace (State or Foreign untry) yland
	pu sees		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryle f eho	ō	Maryland Frederi	ck	Thurmon					1)X∏Yes 2 ☐ No
	28a-	Je C	10e. Street and Number		THUTHOL	10f. Zip Code		1	l0g. Citizen of What Co	untry?
	h with	O IE	126 Sunhigh Driv	e		217	'88		USA	
	death	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Decedent of I	Hispanic Origin? (Span Mexican Puert	pecify Yes or No-	14. Race - Ame Black, White	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Maryland Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎛 Divorced	1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	1984–89	1 ☐ Yes 2½ No		o moan, etc.,	Specify: Wh	
21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. De	cedent's Usual Occu	pation during most of wor	kına	16b. Kind of Business/	Industry
2	ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5	+)	ve kind of work done DO NOT use retire	ed)			
2	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)		Sa	lesman_	18 Mother's Nam	ne (First Middle	Aut Maiden Sumame)	0
Maryland	ld be f ental h ked of	To Be	Edward E		Wimer		Linda	io (i noti maato,	McGarvey	
ary.	2 should and Men Is marke	۲	19a. tnformant's Name/Relationship (· · · · · · · · · · · · · · · · · · ·	ailing Address (Street	I .	ral Route Number	r, City or Town, State, 2	Tip Code)
	1 and 2 Health a	1 17	Edward E. Wimer/Fa	ther	W178	3 N9736 Ri	versbend,	Germant	town, WI 53	022
ore,	es 1 a of He of Hem fitem r othe	- 4	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of Dis	position (Name of rematory or other pla	асө)	Date	20c. Location - City or	Town, State
Ē	Pa Pa		4 Donation 5 Other (Specif	y)	Frederic	ck Cremato		2005	Frederick,	
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe		21. Signature of Funeral Service Licer	1500					neral Home nt, MD 2178	•
-			23a. Part1. Enter the disease or com shock; or heart failure. List only	plications that caused	the death. Do not	enter the mode of dy	ing, such as cardiac	or respiratory arr	est	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Intr	goval	- hotas	inw	round	1 x	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	9				
	LAGITITICI	10	Sequentially list oundfluns	b. Due to (or as	a consequence of):					
	nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 101 43	a consequence on,					
Ć,	ficate be executed physicien and is the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
68760,	te be ysicie	edicai		d.						
_	± on α	Medi	IF FEMALE:							
Вох	death certii e attending nd for use a	lan/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregnanc	у		23d. Date of deli Month	very Day Year
0	0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (specify) _				
۵.	that it		Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
of Vital Records,	The law requires that the ate has been signed by the bage 2 should be detache	ed by						1 🗆 Y	es 2 No 3 □ Pro	obably 4 Unknown
CO	aw require s been si 2 should b	ompieted						24a. Was a		topsy findings available
Ä	The lav	mo:				, ,		autops perform	med? death?	completion of cause of 2 \sum No
ita	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or		
7	w =	P	1XXVes 2 □ No	Hospital:		IBIL 3L DOA			ence 6 X Other (Spec	myat scene
		ertification;	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da	Year Injur	y Wo	iryat ork?]Yes 2 ∀⊘ No	7	ow injury occurred	f seel
Division	tor:	ficat	2 Accident investigation 3 Suicide 6 Could not b	e 28e. Place of Init	ury - At home, farm.	4 PM 1 street, factory, office		28f. Location (S	treet and Number or Ru	ral Route Number.
<u>S</u>	e all a	erti	Homicide determined	building, et	c. (Specify)	1		City or Town	n, State) 12 6 Sw	high Dre
	e Hospital 24 hours a e Funeral D etely filled	edicai C			of my knowledge, de	eath occurred at the t			ause(s) and manner as late and place, and due	
	To the Hos within 24 h To the Fun completely	Medi	one)	and manner sta	ated.		se number		29d. Date signed (Monti	
	5 <u>3 5 8</u>		29b. Signature and title of certifier	L-/	/h]	.M.E.		August 6, 2	
	AVI	3	30. Name and address of person who	completed lausa of d	eath (Item 23a) /Tur					
il)* (5.12, 14	Xn AT)		Street,	Baltimor	e, Maryland	1 21201
-	Sta		31. Date filed (Month, Aay Good 9	2005 32. Refer	ar's Signature	Spark		-		
35	Registr	ar	1100		9					

EUGENE Weightson

1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** enne71 2005 LUGENE 19hTSON Jugust 6 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** EASTON
If Under 1 Year | If Under 24 Hrs. Memoria 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 213-24-0120 1**∑**M 2□F 77 Yrs. OCT. 14, 1927 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumetic event, the Madical Examiner must be natified at 1X Yes 2 □ No Director **EASTON** MD TALBOT 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 700 PORT STREET, Items 23a COTTAGE 342 21601 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Affined Forces: 1 X Yes 2 □ No If Yes, Give Year or Dates: 1945–1946 1 Never Married 2 Married ŏ 1 ☐ Yes 2 No Specify: Specify: WHITE δ 3 ☐ Widowed 4 ☐ Divorced is marked other than "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MANAGEMENT OF GRAIN PRODUCTION POULTRY INDUSTRY -0-12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental I permit. Pages 1 and 2 should be Department of Heath and Mental Importent: If item 27 is marked any injury or other traumetic evone. WILLIAM WRIGHTSON BEULAH SHORE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) THELMA B. WRIGHTSON/ WIFE 700 PORT STREET, COTTAGE 342, EASTON, MD 21601 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTER, LLC 8-8-2005 STEVENSVILLE, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. c.f.sp. Ostesmy 4. oseph 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cerebro disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tension if any, leading to immediate cause. Enter Underlying Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-transit vabetic that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 2FINO Yes Hospital or Attending Physicien: filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one examiner' 1 Tyes 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 TER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Diractor: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State AUG 1 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** John R. White Aug. 2005 10:10 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Manor Chestertown Kent 5. Social Security Number 8. Date of Birth (Month, Day, Y Jan. 17 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X** M 2□ F MIX 215-20-0807 1928 77 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "naturel; or Items 23e or 28e-f show emp injury or other treumatic event, the Medical Event retinant be notified at once. MD Kent Worton 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21678 IISA 10500 Worton Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1X Never Married 2☐ Married 1X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supply Sergeant U.S. Air Force 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Elliott William R. White 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26870 Big Woods RD Worton, MD 21678 Vicky Blizzard/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 8/6/2005 4 □ Donation Chesapeake Crematory Chester, Maryland 5 Other (Specify) 21. Signatur d'uneral Service License ²² Name and Address of Facility
Fellows, Helienbein & Newnam Funeral Home Clows ar 130 Speer RD Chestertown, MD 21620 26a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician COSTRUCTIVE PULMONARY YEMS CHRONIE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, basing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as JE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1∏ Yes 2 No Hospitel or Attending Physicien: 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) examine Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 ☐ Yes 2 X No Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident Director: 6 Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 00057504 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 WASIHINGTON AVE, CHOSTERIOUN, MD Z1620 JANUT CACEY, MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 5 2005 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	Registrar 1. Decedent's Name					of Health and per me G84 of Death	2. Date of Deat Month		Year	3. Time of Dea
ician dical	LeRoy		der Jr.				August	14	2005	1325
niner	4a. Facility Name (If	not institution, give	street and number)		,	wn, or Location of Dea	th		ty of Death	-
			gton Medic	al Cente		Burnie	8. Date of Birth	Anne	Arund	eL ace (State or Fo
al or	5. Social Security Nu 215-86-39	924	2			ays Hours Min		1961	Maryl	ry) ·
	Usual Residence of 10a. State	10b. County	, , , , , , , , , , , , , , , , , , , ,	10c. City, Town	or Location				10	d. Inside City L
ţ	MD	Anne Aru	ındel	Hanove	er					1x Yes 2
Director	10e. Street and Num	ber			10f. Zip Co	ede	1	g. Citizen of	What Count	ry?
<u></u>	89 Ches	apeake Mo	obile Cour	t	2107			U.S.A.		
Funerai	11. Marital Status		12. Was Decedent Armed Forces?		13. Was Decedent If Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ice - America ack, White, e	
by Fu	1 Never Marrie		1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	40	1 ☐ Yes 2 🔯			Speci	ify: Wh	nite
d be		15. Decedent's Ed		162	Decedent's Usual O	Occupation		16b. Kind of E		
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Omo	Elementary/Secon 9th	igary (0-12)	College (1-4or 5	141		rol Techni		Priv	ate	
BeC		First, Middle, Last)				18. Mother's Na	me (First, Middle, M	faiden Suma	ıme)	
To B	LeRoy We	elder Sr.				Ethel M	luth			
Once. To Be Completed by Funeral Director	19a. Informant's Na	me/Relationship (7	ype, Print)			treet and Number or R				
	Ethel V	Welder/Mo	ther			own Drive				20785 —-
	20a. Method of Disp		Removal from State	20b. Place of cemeter	Disposition (Name or other	of r place)	Date	20c. Location	- City or Tov	vn, State
		5 Other (Specify		Mary1	and Natio			Laure1		
DC.	21. Signature₀of Fur	neral Service Licen	see / ///	7			J. B. Jenl			
a	K.	D. Ha	hall			ndover Roa f dying, such as cardia			yland	20785 Approximate
al Examiner		riying injury	c	a consequence of						
dical		(. d							
	IF FEMALE: 23b. Was decedent in the past 12	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregr 5 □ Other (speci				ate of deliver	Y Day Yea
ysician/Me	1 Yes 2 □ 9 □ Unknown						23e. Did tot	acco use cor	ntribute to th	e cause of deat
v Physician/Medic		icant conditions c	ontributing to death b	out not resulting in	the underlying caus	se given in Part I.			3 ☐ Proba	ably 4 🗷 Unki
مَا	Consider III		ontributing to death b	out not resulting ir	n the underlying caus	se given in Part I.		s 2 No		
npleted by	Consider III		ontributing to death t	out not resulting in	n the underlying caus	se given in Part I.	1 Ye 24a. Was a autops perform	n 24b y ned?	death?	sy findings ava apletion of caus
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To Be Completed by	Cocaine Us	red to medical	Hoenital	ent 2 (XX ER/Ou	utpatient 3□ DOA	26. Place of De	1 Yes 24a. Was a autops perform 125 Yes 2	24b y ned? P No	death? 1 Yes ther (Specify	2□ No
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			Registrar 1. Decedent's Name (First, Middle, Last)			061	uncai	O O L	Call	2	. Date of Death	g. N6)	05	-8. Fime of Death
	Physicia		Wilmore Lee	Wells							August	Day 1	2005	5:08P M
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)			4b. City	Town, or	Location of				ty of Death	1
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	Funeral		5. Social Security Number 6. Sex	7. Ag		ast birthday)	If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. 8 Min.	. Date of Birth	Year)	9. Birth	place (State or Foreign ntry)
	Director		217 44 3009	M 2□F	59	Yrs.		,.			Mar. 26	,1946		ginia
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	189 1	Director	10e. Street and Number					p Code	1490		10	g. Citizen of	f What Cou	ntry?
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	deat	Funeral		2. Was Decedent Armed Forces?		S. 13.	Was Dece	dent of His	spanic Orig	jin? (Speci	fy Yes or No-		ace - Ameri ack, White	
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2	filed within 72 Hygiene. other then "nai snt, Ine Medic	duio	Elementary/Secondary (0-12)	College (1-4or	5+)			rpent				const	ructi	on
Ö	be filed within 72 hours after death with the Marylan tal hygiene. d other then "natural", or liteme 23a or 28e-f show event. The Medical Examinational be notified at	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name (i	First, Middle, M	aiden Suma	ime)	
<u>a</u> r		To B	Jesse Wells, Sr.						Lou	uella	Maddox			
Maryland 21215-0036	s 1 and 2 should be (Health and Mental Hitem 27 le marked of other treumatic even	•	19a. Informant's Name/Relationship (Typ				•				Route Number,	City or Town	n, State, Zi	o Code)
	1 and 2 Health tem 27 l		Charles Robertson/s	stepson	look D	2712			cott	Key I				MD 21787
9	Pages 1 nent of Hi int: if iter iry or oth		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Re	moval from State	C	lace of Dispo	natory or	other place				0c. Location	•	
altimore,	t. Partent:		'4 □Donation 5 □ Other (Specify)	01//	Sam	s Cree				3/8/20		Dennin		טו
Ba	permit. Pages Depertment of t importent: if ite any injury or of		21. Signature of Funeral Service License	War 2	les			Broad			ler Fur Union Bi			1701
			23a. Part1. Enter the disease, or complic	ations that caused	the death								110 2	Approximate
	Dharisian		Immediate Cause (Final	e cause on each li	ne.	10								Interval Between Onset and Death Years
	Physician / /Medical		disease or condition resulting in death)	Due to (or as	a consequ	uence of):			_		-			yeur)
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g Q	cate be executed physician and the burial-transit		165 diting in dodiny East	Due to (or as	a consequ	derice of):								
9/8	physis the t	dicai	d.						-					
×	eath certifi ettending I for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	lc. If yes, outcome								23d. D	ate of deliv	ery
ROX	d for t	Physician/Mo	In the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic p Other (s					N	lonth	Day Year
O.	t the by the ache	hys	9 ☐ Unknown	9□ Unknown								.		
S,	The law requires that the death certifi: tte has been signed by the ettending i age 2 should be detached for use as	by P	Part II. Other significant conditions conf	ributing to death b	ut not resu	ulting in the u	nderlying	cause give	n in Part I.					he cause of death?
ord	w require been si should b	ted	Diabetes								1 Z Yes	2 ∐ No	3∐ Pro	bably 4 Unknown
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<u></u>	Phys this ral dii	. To	1 Yes 2 No	1 🗆 Inpatie		ER/Outpatier 28b. Time of		UA	4 🗆 1401		 5 Resider d. Describe how 			fy)
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Division	Atter r dea ector by the	ifica	3 Suicide 6 Could not be determined	28e. Place of In	jury - At ho	me, larm, str	eet, factor	ry, office		28	I. Location (Stre City or Town,	et and Nun	ber or Rur	al Route Number,
ā	tei or s afte ei Dir ed in	Certification:	4 - Hollidge	building, et	ic. (Specif)									
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director,	edical (29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	er: On the basis of	f examinat									
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	WIL		30. Name and address of person who opi		loath (lta-	23a\ /T	Print\	000	217	14		19US	1 21	2003
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N6) 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Barbara Louvenia Williams July 30, 2005 1:30pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Temple Hills
If Under 1 Year | If Under 24 Hrs. 4616 Birchtree Ln. Prince Georges Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Days **Funeral** Hours Min. 238-46-9650 1□M 2√F 72 Director Greenville, N.C 5, 1932 Usual Residence of Decedent with the Maryland 10h County 10c. City. Town or Location 10d. Inside City Limits 10a. State in then "neturel", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Director Prince Georges Temple Hills Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death or Hygiene.

Hygiene.

other than "neturel", or Items 23: 20748 United States Funeral 4616 Birchtree Ln. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 2 3 NWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Educator permit. Pages 1 and 2 should be filled win Department of Health and Mental Hygient Importent: If Item 27 ie marked other tha any injury or other treumetic event, Italy 2006. School Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Lonnie C. Barnhill Julia Keyes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Cutter Court Annapolis, Md. Steven Williams / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 5,2005 Suitland, Md. Aug. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatute of Funeral Service Live see 22. Name and Address of Facility Alexander S. Pope Funeral Homes, P.A. 20747 lange MOIDS Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ancer 6 Varian /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physicien Physician/Medical use as the the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month for Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ 1 Tyes 2 N6 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home SN Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3325 12005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan 110 Junes ST NW Cosin 770 20010 31. Date filed (Month, Day, Year) . Registrar's Signature_ State AUG 0 8 2005 Registrar

_			For State Registrar	State of N	Maryland / D	•	nent of F		R	eg. No. [] (15	27347
	Dhuaisi		1. Decedent's Name (First, Middle,	_ast)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		OLLIE	JUNIOR		WEBB			8	3	05	1:20 PM
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0	Funeral Director		220-52-0916	Sex 7. /	Age (In yrs. last birt	Yrs. Mo	onths Days	Hours Min.	8. Date of Birth (Month, Day MAR • 18	, Year)	9. Birthp Cour. MAR	place (State or Foreign htry) YLAND
4	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location	n .				1	Od. Inside City Limits
0 m	Maryland -f show lied at	ō	MARYLAND WORCE	STER	BERI	LTN						1 ☐ Yes 2 X No
40	the A	Director	10e. Street and Number				Of. Zip Code		1	log. Citizen of	What Cour	itry?
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ンEB SS#。 altimor	permit. Pag Department Important: any injury c		* 4 □ Donation 5 □ Other (Spe		SUNSE		ORIAL E		/05	BERLIN	, MAR	YLAND
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, P.O. Box 68760	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition	4∏Pregnant 9∏Unknowr	2 Fetal death t at time of death	5 🗆 Oti	opic pregnancy ner (specify) lying cause giv		23e. Did to	М	ate of deliver	Day Year
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Division of Vital Records,	sician: The law requir s certificate has been si irector, page 2 should	Completed						<u>. </u>	24a. Was a autops perform	in 24b.	Were autoprior to condeath?	psy findings available mpletion of cause of
ita	ian: rtifica stor, p	a)	25. Was case referred to medical					26. Place of Dea	ith (Check only or			
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0 [Jing Ph J. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of I	njury 28b. 1 Day Year) li	Time of njury	28c. Injur Wor	y at k?	28d. Describe ho	ow injury occu	rred	
ivisio	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of	Injury - At home, fa etc. (Specify)			Yes 2 □ No	28f. Location (Si City or Town		ber or Rura	I Route Number,
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	180		30. Name and address of person w	no completed cause of	of death (Item 23a)	(Type, Prin	1)	1 00		-/-	7	<u> </u>
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	Physici /Medic		1. Decedent's Name (First, Middle,	Francis h	latson			HUGUST	Day Year	-3. Time of Death -6:20 A M	
	Examin		4a. Facility Name (If not institution, Vashy ton Cum 5. Social Security Number	its hospital.	VIV.	If Under 1 Year	tocation of Death Then n . I If Under 24 Hrs.	nD.	c. County of Dea	hplace (State or Foreign	
	Funeral Director		217-64-7684 Usual Residence of Decedent	1 M 2 □ F 5	O Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea Mar. 27, 1	.955 Ma	ryland	
	the Marylar 28a-1 show	ector	10a. State 10b. County Md. W 10e. Street and Number	ashington	c. City, Town or Lo	erstown 10f. Zip Code		100.0	Citizen of What Co	10d. Inside City Limits 1 □X es 2 □ No	
	n 72 hours after deeth with the Maryland "neturel", or Items 23e or 28e-1 show edical Examiner must be notified at	Completed by Funeral Director	11 W. Baltimo	re St. Apt. 9 12. Was Decedent Eve Amed Forces?		21	1740 ispanic Origin? (Spanic, Mexican, Puerto		U.S.	A nican Indian,	
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21215	c * W	Complete	(Specify only highest Elementary/Secondary (0-12) 12	grade completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired Driver	during most of worki	ing	16b. Kind of Business/Industry Truck		
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than other treumetic event, the M	To Be (17. Father's Name (First, Middle, L Raymond P.	Watson	W		G	e (First, Middle, Maide ayle A. Fo	ster		
_	2 g a a		19a. Informant's Name/Relationsh Patsy V. Buhrma	n (Fiancee)		Baltimo	re St. Ap	t.608 Hage	erstown,	nd. 21740	
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 □ Purial 2 □ Cremation 1 □ Donation 5 □ Other (Sp	3 □Removal from State ecify)	cemetery, cren Smithsbur	g Cemeter	ry 2005	.18,	Location - City or Smithsbur		
Ball	permit. Pag Depertment Important: I eny injury o		21. Signature of Funeral Service L	icensee Mo. Lee Davis	7 7	. Name and Addres	ss of Facility Funeral	Market Street Control of the Control	Bradbun	The second second second	
	Physician /Medical Examiner	ner	23a. Part1. Enter Las sease, or shock, or hear failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	Due to (or as a co	onsequence of):	ar the mode of dying the construction of the c	g, such as cardiac of	·	hour.	Approximate Interval Between Onset and Death	
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	w requires that the del been signed by the a should be detached f	ed by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Mnltrule at all.						23e. Did tobacco use contribute to the cause of death? 1 Yes		
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f Vita	ding Physicien: After this certific Luneral director,	To Be	25. Was c referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2DER/Outpatien	t 3 DOA Othe	00	me 5 ☐ Residence	6 □Other (Spe	cify)	
Division of	fter	Certification:	27. Manner of Death 1	ation		M 1 🗀	Yes 2□No	28d. Describe how in			
Divi	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the lu	Certif	4 Homicide determi	ned 286. Place of injury building, etc. (Specify)			28f. Location (Street City or Town, Sta	ate)		
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	Tot Tot com	M	29b. Signature and title of certifier	(m 1)		29c. License			Studyout		
6	٦		30. Name and address of person of GNUVING XU	. 324. E.	Antretum	Print)	203. Ha	gatown.	m1) 21	140	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	balls					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** August 9, 2005 9:10 P. Fredrick Paul Wasson /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mechanicsville St. Mary's 27465 N. Sandgates Road 8. Date of Birth (Month, Day, July 3, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1(XM 2□ F 1939 Director 424-46-8969 Muncie, 66 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
nt: If Item 27 is marked other then "natural", or Itema 23a or 28a-f ehow 10c. City. Town or Location 10d. Inside City Limits 10b County 10a State Item 27 le marked other then "natural", or Itama 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Mechanicsville Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20659 IISA 27465 N. Sandgates Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Yes 2 □ No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government Contract 12 Electronic Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ျှ Florence Lucile Boram Marshall Paul Wasson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gladys Lavern Wasson/Wife 27465 N. Sandgates Road, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ⊠ Burial 2 □ Cremation 3 □ Removal from State 5 permit. Page Department of Important: If any injury or once. Maryland Veteran Cemetery | Aug 15, 2005 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P. O. Box 270, Leonardtown, MD 20650 Mattingley-Gardiner Funeral Home, P.A. richay Part1. Enter the disease, or domplications that caused the de shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Metastatic **Physician** Color 3years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death signed by the aid 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by arte 1 ☐ Yes 2 No 3 Probebly 4 □Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 200 No 1 ☐ Yes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 4 hours after deam.
Funeral Director: After this c 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D19917 110 05 90

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 1 1 2005

/Dr. James C. Boyd, Wildewood Shopping Center, California, MD

32. Registar's Signature

DHMH 17 Rev 1/2001

Registrar

AUG 0 8 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1 5 2. Date of Death . Decedent's Name (First, Middle, Last) Month Day Year Physician 2005 8:27 P Shirley Sue White August 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Frederick Kline Hospice House Mt. Airy Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 1 1 F 217-42-3076 61 May 9, 1944 Mississippi Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County in than "natural", or items 23a or 28a-f show the Medical Examinational be notified at 1 ☐ Yes 2\X\No Frederick Mt. Airy Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12401 C Old Annapolis Road 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed . 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home Pages 1 and 2 should be filed nent of Health and Mental Hygirint: If item 27 is markad other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Peggy Ann Brasher Thomas W. Phelps ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Mabry / Daughter P.O. BOX 319, Gerrardstown, WV, 25420 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 8/9/2005 Frederick, Maryland • 4 □ Donation 5 □ Other (Specify) Resthaven Memorial 21. Signature Juneral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Circhairs **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician by Physician/Medical as the t 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐ Pregnant at time of death 5 Other (specify) page 2 should be detached 9☐ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Hone 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Mannet of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DI 6935 8/5 Criz 36~ 30. Name and address of person who completed cause of death (Item 23a) (Type, Pri 3ehra 31. Date filed (Month Cay O Registrar's Signature State 2005 Registrar

			For State	State of Ma	ryland		artment of H			ental Hy	giene			
			Registrar 1. Decedent's Name (First, Middle, Las	t)		Cei	tillicate of t	Deau		2. Date of De	Reg. No.	005	3. Time of Death	
ı	Physicia /Medic		Agnes Bernice	Yates						Month 08	Day	3005	11:35 A M	
}	Examin	er	4a. Facility Name (If not institution, give	í	- 1		4b. City, Town, or	r Location	4.4		_	County of De		
			5. Social Security Number 6. Se	d Medical S	Un vrs. le	m S ast birthday)	If Under 1 Year		Mary or 24 Hrs. Pe	B. Date of Bi	th	Bultino	irtholace (State or Foreign)
	Funeral Director			M 2 <u>Ş</u> ⊋F	69		Months Days	Hours		(Month, Da 2-14-1	ay, Year)	0	Country) ary Land	
	ס		Usual Residence of Decedent		10- 01-	. Town or Lo							10d. Inside City Limits	_
	anylar show	'n	10a. State 10b. County Maryland St. Mary	.1.0			csville						1 ☐ Yes 2½ No	
	28a-f	Director	10e. Street and Number	7 5	rie	Chani	10f. Zip Code				10a. Citi	zen of What C	Country?	
	3a or		26175 Barnes Cour	• *			20659				Uni	ted Sta	ates	
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	3. 13.	Was Decedent of H	lispanic C	origin? (Spec	ify Yes or No)-	14. Race - Arr Black, Wh		
စ္တ	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ N If Yes, Give	0	+	1 ☐ Yes 2 ☐ No	Specif		,,		Specific		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. whar than "natural", or Items 23s or 28s-f show with the Medical Examination mat be rediffed at	ed by	3 XWidowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:		16a Dece	dent's Usual Occup	ation			16h Ki	nd of Busines	31ack s/Industry	
5	in 72 n "nai	plete	(Specify only highest gra	de completed)	.,	(Give	kind of work done	during me	ost of working	7	100.10			
212	d with	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	*/		Cook					Food	Service	
pu	tat Hy d oth	Be (17. Father's Name (First, Middle, Last)					18. Mot	her's Name (Sumame)		
yla	Men Men Marke	2	John Francis You			405 14-15	ng Address (Street			Lee Cl		- Tour State	Zin Code l	
Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (7 Charlene Yates/I				l Satchel							
ق	Heall Heall tam 2 othar		20a. Method of Disposition		20b. Pl		esition (Name of matory or other place		Da			cation - City		
OE .	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify				Memorial		8-13-2	2005	Leon	nardtov	m, Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked othar than "natural; or Items 23a or 28a-f show any injury or othar traumatic evant. It is Medical Examinat must be retified at ance.		21. Signature of Funeral Service, Leon	ld, Jr. MC	00052		2. Name and Addre 2955 Holl						lome, P.A.	
			23a, Part1. Enter the disease, or comp	olications that caused	the death								Approximate	
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	/Medical		disease or condition resulting in death)	a Lntruc		ence of):	temorrhag	e					24 1005	
Ü	Examiner		Sequentially list conditions,	b. Hyperte		•							Multiple Years	
	pe sit	lner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequ	ience of):								
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8760	death certificate be executed e attending physician and od for use as the burial-transit	cal		d										
9	tificate ng phys as the		IEEE/III											
Вох	leath certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth		death 3	∃Ectopic pregnancy	у				23d. Date of d Month	elivery Day Year	
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CO	aw requir as been si 2 should	ompleted	J. ,							24a. Was		24b. Were	autopsy findings available o completion of cause of	•
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	ro the within Fo the	Me	29b. Signature and title of gertifier				29c. Licens	se numbe	f		29d. Da	te signed (Mo	nth, Day, Year)	
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	4		30. Name and address of person who	completed cause of de		23а) (Туре,	Print)			,		fil sfi		
	/		David Thrahimi M. 31. Date filed (Month, Day, Year)				est Bulti	more	Mary	land	3120	1		
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03798	M	anuel Aguilar				
		Please	Type or Print in Black			egible.
		1_ State		partment of Health and M	Mental Hygiene	
		1 - State Registrar 1. Decedent's Name (First, Middle, Last		ertificate of Death	Reg. No. 2	005 27353
Physic	4.5	Manuel Aguilar	,		Month Day	Year 2005 5:14A. M
/Med Exam		4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death	JUNE 3,	2005 5:14A. M
		6360 NEW HAMPSHIRE	E AVE	TAKOMA PARK		ICE GEORGES
Funera Directo			x 7. Age (In yrs. last birthda ŽM 2□F 50 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sept 15, 195	9. Birthplace (State or Foreign Country) unk
Maryland f show	or	Usual Residence of Decedent 10a. State UNK 10b. County	unk 10c. City, Town or	Location		unk 10d. Inside City Limits unk₁ ☐ Yes 2 ☐ No
death with the Maryland me 23e or 28e-f show Frinset be notified at	I Director	10e. Street and Number	ur	k 10f. Zip Code	unk 10g. Citizen	of What Country? unk
	by Funeral I	11. Marital Status unk 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No unk If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		Race - American Indian, Black, White, etc. ^{ecity} : white
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mantal Hygiene. It is marked other then "natural", or treumetic event, the Modical Exercitivements of the control of th	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation 16a. Dec e completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	11mle 16b Kind o	of Business/Industry unk
and 21215-0 be filed within 72 ho stal Hygiene. The dother instead event, the Medical	Be Com	1-	unk	unk 18. Mother's Nam	e (First, Middle, Maiden Sur	mame) unk
Aaryland 2 should be and Mental. is marked o	To	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b. Ma	iling Address (Street and Number or Rur	al Route Number, City or To	wn, State, Zip Code)
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other treumetic any injury or other treumetic any injury or other treumetic any injury or other tre		O.C.M.E. 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F '4 □ Donation 5 ☑ Other (Specify)	20b. Place of Discemetery, co	Penn Street Baltin	more, MD 2120	
Balti permit. Departrr Importa any inju		21. Signature Funeral Service License Rangeld S. J	Wade Director	22. Name and Address of Facility State Anatomy Boar Baltimore, MD 212		timore Street
Physician /Medical Examiner		23a. Park. Enter the disease, or complished or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	cations that eaused the death. Do not enter the cause on each line. Due to (or as a consequence of):	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
scuted ind transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of).			
Records, P.O. Box 68760, The taw requires that the death certificate be exe tab has been signed by the attending physician at age 2 should be detached for use as the burial:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		Date of delivery Month Day Year
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	Completed	OS Wassess referred to market			24a. Was an autopsy performed? 1 X Yes 2 □ No	b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No
of Vital Physicien: T this certificate ral director, pa	To Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	ospital:	04	n <i>(Check only one)</i> me 5□ Residence 6 X (CCENT
on o	Certification; T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Time Injury 5: 02 28e. Place of Injury - At home, farm, s	of 28c. Injury at Work? M 1 □ Yes 2 1 No	28d. Describe how injury occ Pedestrian Str	
Divisit To the Hospital or Attent within 24 hours after does To the Funeral Directors completely filled in by the	Cert	4 Homicide	building, etc. (Specify)	4	City or Town, State) AVR Takoma	5360 New Hampshire
Hosp. 4 hou Funer ely fill		29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my knowledge, dealer: On the basis of examination and/or i	th occurred at the time, date and place :	and due to the cause/s) and	manner as stated
thin 2.	Medical	one) 29b. Signature and title of certifier	and manner stated.			
Twin 00		29b. Signature and title of certifier	m.D	29c. License number OCME		ned (Month, Day, Year)
1		30. Name and address of person who col			JUNE 3,	2005
		LING LI	, miD	111 Penn Street	Baltimore,	Maryland 21201
Sta Regist		31. Date filed (Month, Day, Year) AUG 2 2 2005	39 Registrar's Signature	wie		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2005 18 /Medical 4a. Facility Name (Innot institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Randallstown Hospita BALTIMORE Northwest If Under 1 Year | If Under 24 Hrs. 8 Date of Birth Months Days Hours Min. NOV. 17, 1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ₹ M 2 □ F NY 120-01-2335 84 Yrs Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Item 27 is marked other then "netural", or Items 23a or 28e-f show other treumatic event, the Macdical Examiner must be notified at 1 ☐ Yes 2 🔀 No Directo BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21208 USA 7427 PRINCE GEORGE ROAD Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? WW I I 1 WYes ≥ □ No NAVY If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other then "netural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES FLOORING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LIEBERMAN (UNKNOWN) HARRY anna 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7427 PRINCE GEORGE ROAD - BALTIMORE, MD 21208 DOROTHY ALLEN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. ANSHE EMUNAH) AITZ CHAIM 8/19/05 HALETHORPE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Tolar 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Multiple organ >48hours /Medical **Examiner** >72hours syndrome DIFO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 week pancrea IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown malnutrition Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hronic certificate has autopsy performed? Yes 2 2 No disease / Tschemic cardiomy posthy 1 Yes 20 2 🗆 No 1 Yes erebrovascular Be 25. Was case referred to medical examiner? Hospital: 1 √Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 🗌 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours aft To the Funerel Di completely filled in t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier ical ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 28462

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Hospital

Center Randallstown, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

Boston

31. Date filed (Month, Day, Yeer)

Northwest

32, Registrar's Signature

		4	For State Registrer	State of N	/aryland / [Departmen <i>Certificat</i>			nd Ment	al Hygier	2000	27355
	Physicia	an	1. Decedent's Name (First, Middle, La:	STOW					M	ate of Death	Day 16 Ju	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv		_		Town, or I	Location of			4c. County of D	eath /
-	Funeral	-	5. Social Security Number 6. S	ex 7.	MEDILAL (Age (In yrs. last bii	rthday) If Under		If Under 2	100 8. D. Min. 8. D.	ate of Birth fonth, Day, Ye	9	Birthplace (State or Foreign Country)
T	Director		214-52-9773	□M 2 X (F	56	Yrs. Months	Days	Hours			949	Maryland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Location						10d. Inside City Limits
	e Mary	ctor	Maryland Anne A	rundel	H	anover						1 ☐ Yes 21 No
	with th	Directo	10e. Street and Number	_		10f. Zip					Citizen of What	Country?
	death ms 23	Funeral	7215 Ridge Roa	12. Was Deceder Armed Force	nt Ever in U.S.	13. Was Dece If Yes, spe	1076	spanic Orig	gin? (Specify)			merican Indian, /hite, etc.
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21215-0036	in 72 hours after death with the Marylan "naturel", or Items 23e or 28e-f ehow te figal Examinal mast be nutified at		15. Decedent's E	Year or Date:		. Decedent's Usu	al Occupa	tion	at wasting	16b	. Kind of Busine	White ess/Industry
215	d within 7; jiene. r then "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-40	or 5+)	(Give kind of wo life. DO NOT u	se retired)	unng most	or working			
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<u>Ilan</u>	d a b	To Be	Charles Pitzing	ger				Eve	elyn	Gey		
Maryland	and and le m		19a. Informant's Name/Relationship (o. Mailing Address						
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OE.	0 0 = =		1 ☐ Burial 2 🔀 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special		re	peake Cr			8-22-20	005	Beltsvi	lle, MD
Baltimore,	permit. Pag Department Importent: any injury c		21. Signature of Funeral Pervice Lice			22. Name a	nd Addres	s of Facility	y Dan Elean	ori force	+ M	MD TNG
	40244		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caus	sed the death. Do	7250 not enter the mod	Wash	ningto	on Blvo cardiac or resp	oiratory arrest,	ridge,	MD 21075 proximate Interval Between
	Pnysician		shock, or heart failure.* List only Immediate Cause (Final disease or condition	CONG	ESTIVE	HEART	FAIL	URE				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	ESTIVE as a consequence	of):	>+-	C150				15 VEARS
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. KHRU Due to (or	as a consequence	of):	DASA	EN-WIE				13 NOTE
2	icuted nd transit	Examiner	that initiated events	c								
8760,	be executed sician and burial-transit		resulting in death) Last	Due to (or	as a consequence	or):						
9	ificate g physi as the l	ledic		d								
Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 manths?		2 Fetal death						23d. Date of Month	delivery Day Year
	that the dea led by the at detached fo	yslci	1 ☐ Yes 2 MNo 9 ☐ Unknown	4□Pregnan 9□Unknow	t at time of death	5 Cother (s	pecify)					,
s, P.O.	res that i		Part II. Other significant conditions	•	_	, -	cause give	en in Part I.	. :			e to the cause of death?
ords	w raquire been sig should b	ted	CHRUNIL REMA		+ICIENCE	}				1 🗆 Yes		Probably 4 Unknown
of Vital Records,	ne law has b ge 2 st	Completed by	DIABETES MEL	LITUS						24a. Was an autopsy performed	prior deat	e autopsy findings available to completion of cause of h?
ital	sicien: The law s certificate has t lirector, page 2 s	a	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·			26. Place	of Death (Ch	Yes 2 🗆 eck only one)	No 1	Yes 2 X No
of V	Physicien: this certificated director,	To B	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inp				4 🗆 140		5 Residence	e 6 Other	Specify)
	ding P	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation			Time of Injury M	28c. Injury Work 1 □ 1	rat ⟨? Yes 2.⊟1		Describe now i	rijury occurred	
Division	r Attendi er death. rector: A by the fu	tifica	3 Suicide 6 Could not be determined	289. Place of	Injury - At home, f	arm, street, factor	y, office			ocation (Stree City or Town, S		r Rural Route Number,
Ö	urs aft urs aft arel Di		Constitution D	4		- dath assume		o data an	d plane and o	his to the cause	a/s) and manns	ur ac etated
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate the completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying P (Check only 2 Medicel Exa	hysician: To the be miner: On the basi and manner	s of examination a	nd/or investigation	n, in my op	oinion, deal	th occurred at	the time, date	and place, and	due to the cause(s)
	To th within To th comp	Me	29b. Signature and the of certifier			29	c. License	-	,			fonth, Day, Year)
	7		30. Name and odress of person who	IM SURVEY	y Felion	(Tuna Brint)	1-11	1751		Auc	fust 16	, 205
	10		30. Name and odress of person who MICHARL EBICION, M 31. Date filed (Month, Day, Year) AUG 2. 2	D 22 Su.	TH GREENE	57. BAL	TIMU	E, N	10 212	-01		
		ate	31. Date filed (Month, Day, Year)	32. 899	istrar's Signature	book	1	7 ,	, , , , , ,			
	Regist	rar	AUG 2 2	ZUUD Z	1500 10	1						

	-	State Registrar		artment of Health and Natificate of Death	Reg. 2. Date of Death	2005	27356
Physicia /Medic Examin	in al	Decedent's Name (First, Middle, Last) Diane Bradford A. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Death	Month	Day Year 3 05 4c. County of Death	0905
Funeral Director	G1	Union Memorial 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,	Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 12-19-5	ar) 9. Birth Cou	nplace (State or Foreig untry)
	tor	Usual Residence of Decedent 10a. State 10b. County MD	10c. City, Town or L Baltim				10d. Inside City Limit ∰∏Yes 2 ∏N
23a or 28a st be not	Funeral Director	10e. Street and Number 2346 Belair Rd		10f. Zip Code 21 21 3	10g. US	Citizen of What Cou	untry?
yes fairs and some some some some some some some some	þ	11. Marital Status 1: 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes No If Yes, Give year or Dates:	Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: Bla	, etc.
ene. than "natur re Mavacal I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th	completed) (Givi	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) Tk	king	. Kind of Business/led. Gov	
Mental Hygin arked other atic event,	36	17. Father's Name (First, Middle, Last) George Covington		Willie	Belle Gi	ilmore	
E N =		19a. Informant's Name/Relationship <i>(Typ</i> Treena Rich (Dau	ghter) 2346	ling Address (Street and Number or Au Belair Rd. Ba	ltim oe e,	MD 2121	3
Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposer cemetery, cre Mt. Car	osition (Name of amatory or other place)		Location - City or I	
Departm Importar any injur		21. Signature of Fune at Service License		22. Name and Address of FacilityWes	-		
hysician /Medical xaminer		23a. Part 1. Enter the disease or compile shock, or heart failur List only on Immediate Cause (Final disease or condition resulting in death)	ations that cause the death. Do not end of each of each line. Due to (or as a consequence of):	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
iysician and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
attending pl for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of deli	very Day Year
n signed by the a	by	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to	 .
cate has been signed by the attending ph. page 2 should be detached for use as th	Completed				24a. Was an autopsy performer	prior to death?	topsy findings availa completion of cause 2 \(\sumbolea\) No
within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of eath 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 EP/Outpati 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ent 3 DOA Other: 4 Nursing F	ath (Check only one) Home 5 Residence 28d. Describe how		cify)
within 24 hours after death To the Funerel Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	7	City or Town, S		
within 24 hours after of the Funerel Directompletely filled in by	Medical	(Check only 2 Medical Examir one)	ician: To the best of my knowledge, de- ler: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occi	urred at the time, date	and place, and due	to the cause(s)
To t Com	Σ	29b. Signature and title of certifier Relectah R	Shursen Mr	29c. License number D 00613 e. Print) Union M		Date signed (Month	•
		30. Name and address of person who co	mpleted cause of death (Item 23a) (Typ	1D Union H	lemorial	Hospit	al, 140

State of Maryland / Department of Health and Mental Hygiene
1- State Amend Items# 10f &19b per FH Certificate of Death
Reg. No.

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month BALFOUR 2005 1:45 AM **Physician** AUGUST DOHN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death RAND AUSTOW 4c. County of Death Examiner BACILMORE HOSPITAL CENTER NORTHWEST If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) March 16 1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 □ F RT039-03-2470 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Md ral, or items 23a or 28e-f show Examiner must be notified at Baltimore Randallstown 1 ☐ Yes 2 ☑ No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21134 **21133** 33 Millstone Road USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Yes 2 □ No WW∐I If Yes, Give filed within 72 hours after 1 Never Married 2 Married white 1 ☐ Yes 2 ¥☐ No Specify: Specify: Baltimore, Maryland 21215-0036 lf¥es, ⊍ive Year or Dates: Completed by 3 Widowed 4 Divorced "neturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than "neturent, the Medical Elementary/Secondary (0-12) College (1-4or 5+) contracting engineer engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F John James Balfour Sr. Eva Maude Sherman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shirley Balfour (spouse) 33 Millstone Rd., Randallstown, Md 21136 21133 item 27 I 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or oti
once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State All County Cremation 8-20-05 Sykesville, Md * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel Parge Harght Sterbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARCINOMA Immediate Cause (Final disease or condition resulting in death) DUADENAL Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, nding physician Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by METASTASES. 3 ☐ Probably 4 ☐ Onknown PULMONARY EXTENSIVE 1 ☐ Yes 2 ☐ No EMBOLI. ULMONARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ARTERY DISEASE CORONARY 1 Yes 2 No 1 Yes 2 **\ \M**c 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Dinpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 6 Other (Specify) Certification: To his 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29c. License number 23 29d. Date signed (Month, Day, Year) PHYSICIAN 29b. Signature ar the of certifier 2005 AUGUST 19 tann Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWEST WEST SEEL MID HOSCITAL CENTER MY & MA HALLI COURT KOAD 31. Date filed (Month, Day, Year) 32. Reg State AUG 2 2 2005 Registrar

			State of Maryland / Department State of Maryland / Department Certificate	of Health and of Death	_	giene Reg. N2 0 0	5 27358
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	Day Y	3. Time of Death 9:15 A M
	/Medic	al	Raymond Lee Bosley la. Facility Name (If not institution, give street and number) 4b. City. 1	Town, or Location of De	August	4c. County of	
	=xamin	ei	Hospice of Baltimore Gilchrist Center Tows			Baltimo	re
	- Funeral Director		5. Social Security Number 219-42-9817 6. Sex 10 M 2 F 61 7. Age (In yrs. last birthday) 1. Months 6. Months		In. B. Date of Bin (Month, Da Aug. Z	7, 1943 N	B. Birthplace (State or Foreign County) Maryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	ith the Marylan or 28a-f show	ctor	MD Baltimore Cockeysville				1 ☐ Yes 2 No
	death with the Maryland ms 23s or 28s-f show r nust be notified at	Director	104.2 Saxon Hill Drive 106. Zip v			10g. Citizen of Wh	at Country?
	death ms 23	Funeral		ent of Hispanic Origin? fly Cuban, Mexican, Pu			- American Indian,
9	or Ital	/ Fur	1 Never Married 2 Married 1 MYes 2 No		ierto Rican, etc.)	Black, Specify:	White, etc.
	hours fural',	ed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual	I Occupation		16b. Kind of Busin	white ness/industry
15×100	hin 72 a. an "ne Medic	Completed	(Specify only highest grade completed) (Give kind of work life. DO NOT use	k done during most of v e retired)	working		·
7 2	led wit lygiene her tha	Con	TZ T CTATIIS AUJ		Name (First, Middle,	Insuranc	
9154M Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic avent, the Medical Examinar must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Thomas E. Bosley		s G. Baum		
Mary	12 shorth and h			(Street and Number or			
	s 1 and Healing Healing 1	1	20a. Method of Disposition 20b. Place of Disposition (Nam	Hill Drive	Date	20c. Location - Ci	
3/C	Page ment o ant: If ury or		4 Donation 5 Other (Specify)		22/05	Towson, M	
<u> </u>	Depart Depart Import any in			d Address of Facility WSON Funera	al Home		ork Road , MD 21204
∞	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only out cause on each line.		diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a. Ma iguar Wes; lash Due to (or as a consequence of):	Lung			MonThs
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	cate be executed oblysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c				
8760	cate be c shysician the buri	licai	d				
() ×	aath certific attending pl	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	. ***		23d. Date	of delivery
S. Bo	wrequires that the death certific been signed by the atlending t should be detached for use as	Physician/Med	250. Was decemb pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pre 4 □ Pregnant at time of death 5 □ Other (spe		AND THE	Month	
rdsb.	quires that n signed to ald be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	iuse given in Part I.			ute to the cause of death?
Vital Record	2 2	Completed			24a. Was autop perfo	ormed? dea	ere autopsy findings available or to completion of cause of ath? Yes 2170
It I	ian:] attifical ctor, p	BeC	25. Was case referred to medical examiner?	26. Place of I	Death (Check only o		1195 20g/NO
\$ 5	Physic this ce al dire	P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DO		g Home 5 Resid		
ono	ding F th. After funer	tlon:	27. Manner of Death 1 12 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	280. Describe	how injury occurred	
Division	or Attantier deat	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	, office	28f. Location (: City or Tox		or Rural Route Number,
۵	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	calCe	29a. Certifier (Check only 1 Certifying Physicien: To the best of my knowledge, death occurred a 2 Medical Examiner: On the basis of examination and/or investigation,	at the time, date and pla	ace, and due to the	cause(s) and mann	ner as stated.
	the H thin 24 the Fi mplete	Medical	one) and manner stated.	License number	couried at trie time,	29d. Date signed (
	To Too			0061199		Aug. 21,	, ,
	10+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		-		
_	4.7		Just Black. 660 I North Charles Stre	et, lousum	MO 21	204	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 2 2005 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** BRADSHAN 7.45 PM JOHN 145 2005 3 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE FUTURE CARE BALTIMORE HOMENSOD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 266-64-6411 Months 12M 2□ F Maryland Director Usuel Residence of Decedent tha Maryland 10e. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Show r than "natural", or items 23a or 28a-f show the Medical Experimen must be notified at Directo社 MD H⊋Yes 2□No Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 2700 N. Charles Street 21218 Funeral <u>USA</u> filed within 72 hours after daath Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: black <u>۾</u> 3 ☑ Widowed 4 ☐ Divorced Completed unk 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) unk unk parmit. Pagas 1 and 2 should be filed Dapartment of Haalth and Mantal Hygii Important: if Item 27 is marked other: eny Injury or other treumatic event. unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2700 N. Charles Street Baltimore, MI)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - C Future Care Homewood 21218 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wald S. Wade State Anatomy Board 655 W. Baltimore Street rector 21201 655 W. Baltimore, MD Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical CARGNOMA OF LUNS Examiner Due to (or es a consequence of): Examiner PERPHENNIL VASCULAR DISEATE attending physician end for usa es tha buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): AMPUGA CLON LOOVE BILATERAL KNEE Box 68760. Physician/Medical Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. n signed by th. 1 ba def 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ¥69 242No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Mennef of Death Aftar Attending 1 Natural 5 Pending 1 Yes 2 No daath. investigation To the Hospital or Attendit within 24 hours effer death. To the Funerel Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 D0056948 NUG PRIMARY CARE 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

Registrar

State

ANDINO 4

70 32. Registrer's Signature

JAMES

31. Date filed (Month, Day, Year) AUG 2 2 2005

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mar		artment of r rtificate of		ı Mental Hy	/giene Reg. No./	2005	27260
	E S		1. Decedent's Name (First, Middle, Las	t)				2. Date of D Month	eath Day	Year	5: Time of Death
	Physicia /Medic		DENISE			BRIX		Augus	t 2,	2005	4:38 P M
Examiner			4a. Facility Name (If not institution, given 1906 Ramblewood F	street and number) load Apt. I	A	4b. City, Town, o		eath	4c. (County of Death	N/A
83	Funeral Director		5. Social Security Number 6. Se UNK	7. Age (1	(In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		rth av. Year) 26,19:	9. Birthp Cour	place (State or Foreign MD
	nand ow		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	cation					0d. Inside City Limits
	a-fsh	ctor	MD N/A		BALT	IMORE					1 √ Yes 2 No
	or 28	Director	10e. Street and Number	_		10f. Zip Code			10g. Citiz	en of What Cour	ntry?
	e 23a	eral	1906 RAMBLEWOOD			W- B	21239	/2 // //			USA
020	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "naturel", or Iteme 23a or 28a-f show event, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ♥ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of HITYes, specify Cub 1 ☐ Yes 2 1 No	an, Mexican, Pu Specify:	(Specify res of Nerto Rican, etc.)		 Race - Americ Black, White, Specify: 	
ה ה	"natu	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Docup	during most of v	working	16b. Kin	d of Business/Inc	dustry
7	withir ene. then	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)	NURS	DO NOT use retire: SF	a)		NURS	SING	
2	m = 0 S	a	17. Father's Name (First, Middle, Last)		Horte	· -	18. Mother's N	lame (First, Middle			
N O	should be nd Mental marked c	To B	HEGURU		TOKUNA	IGA	IDA	А			SWENSON
200	s 1 and 2 should if Health and Men Item 27 is marke other treumatic		19a. Informant's Name/Relationship (7			ng Address (Street					Code)
ָב ב	1 and Healt tem 2:		DENISE BEEK / G 20a. Method of Disposition	RANDDAUGHTE	20b. Place of Dispo	NINSULA psition (Name of		Date		ation - City or To	wn. State
<u> </u>	Pages nent of int: If It iry or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	HILLTOP S	natory`or other pla	1	/19/2005		TOWSON,	
	permit. Pages Depertment of Important: If I eny Injury or once.		21. Signature of Funeral Service Licen			2. Name and Addre		SOL LEVIN			
 	40 = 0		Cy Clay	eu-	8	900 REIS	TERSTOW	N ROAD -	PIKES		MD 21208
	Discostolare		23a. Part Enter the disease, by comp shook, or heart failure. List only of Immediate Cause (Final	_	6.						Approximate Interval Between Onset and Death
) e ₂ -	Physician /Medical		disease or condition resulting in death)	a. Drowning Co	consequence of):	atheresel	levoir ca	Lower	ar dis	ease	
	Examiner		Sequentially list conditions.	b							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
,	execu n and ial-tra	Exar	that initiated events resulting in death) Last	C.							
00/00	rificate be executed ng physicien and as the burial-transit	Aedical	(d							
	certifica ding pl	/Med	IF FEMALE:	23c. If yes, outcome of	Dragnanov						
.O. DOX	To the Hospitel or Attending Phyeiclen: The law requires that the death cer within 24 hours after death. To the Funerel Director: After this certificate has been signed by the ettendir completely filled in by the funeral director, page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 □Unknown	1 Live birth 2 [4 Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify) _	у		23	3d. Date of delive Month	ny Day Year
v. L	s that gned b	by Pi	Part II. Other significant conditions co	ontributing to death but r	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco us	e contribute to th	e cause of death?
ecorus,	Ben si		HypeAthermia					1 🗆	Yes 2	No 3 □ Prob	ably 4 □Unknown
2	he law e has b age 2 st	Completed								prior to cor death?	osy findings available inpletion of cause of
N 11 2	len: T	0	25. Was case referred to medical				26. Place of D	1 Yes Death (Check only	2□No one)	1 Yes	2 No
> 5	hyeic his ce	To B	IMMes 5□ 40	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3□ DOA Oth				Other (Specify	at scene
=	ding P	ilon:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury Month, Day Y	Fra. 100	Wor	rk?	28d. Describe Subject d	how injury	occurred u	kus expased
VISION	death death ctor: y the	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	August 2,2005	- At home, farm, str	P	Yes 2/3/No	roelevate	1 enn	Number or Rura	temperatures
2	el or / s after of in b	Certi	4 Homicide determined	building, etc. ((Specify) home,	out, lactory, office		City or To 1906 RA	wn. State)	101	Amore MO
	Hospit 24 hour Funera	edical (29a. Certifier 1 Certifying Phy (Check only one)	ysician: To the best of n	my knowledge, death	n occurred at the tir vestigation, in my o	me, date and pla ppinion, death oc	ice, and due to the	Called(s) a	nd manner as st	ated
	ro the	Med	29b. Signature and title of certifier	and manner stated	u.	29c. Licens				signed (Month, I	
)	->-0		Joshone	enf MD		O.C.M.	.E.			st 3, 20	
	10		30. Name and address of person who o	completed cause of deal	th (Item 23a) (Type,				04	,	
	Ų		Tasha L. G. reent 31. Date filed (Month, Day, Year)	sery M.D.	111	Penn Str	reet, Ba	ltimore,	Mary.	land 21	201
F. 26	Sta Registr		ALIG 9 2 20	32 Registrar's	Signature Acce	and I					

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Records,

Division of Vital

			1 - For State Registrar	State	of Maryland / Dep <i>Ce</i>	artment of He		Mental Hygie	2005	27362		
			Decedent's Name (First, Midd	le, Last)				2. Date of Death	45000	3. Time of Death		
	Physici		Suzanne S.	Carnev				August 15	Day 2005	3:42 AM™		
	/Medic Examir		4a. Facility Name (If not institution		mber)	4b. City, Town, or L	ocation of Death		4c. County of Deat			
	LXdIIII	iei	Shady Grove		•	Rocky			Montg			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign		
	Director		529-54-9427	1□M 2\F	65 Yrs.	Months Days	Hours Min.	Jan 17. 1		unk unk		
	D		Usual Residence of Decedent					5411 17.6 1	J-10			
	rylan	_	10a. State 10b. County	1	10c. City, Town or L	ocation				10d. Inside City Limits		
	Ba-f s	cto	MD Mont	gomery	Montgo	mery Villa	age			1 Yes 2 No		
	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?		
	within 72 hours after death with the Maryland ane. than "natural", or Iteme 23s or 28s-1 show ta Medical Examatar must be notified at	le I	19405 Thomas	Farm Road)886		USA			
	r deg	Funeral	11. Marital Status	12. Was Dec Armed F	edent Ever in U.S. 13. orces?	Was Decedent of His If Yes, specify Cuban,	panic Origin? (Sp. Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, White			
36	or It		1 Never Married 2 Mar	If Yes. G	2 X No		Specify:	, , , , ,	Specify: wh			
21215-0036	ural	Completed by	3 ₩ Widowed 4 Divorce									
5	"nat	lete		nt's Education ast grade completed	(Give	dent's Usual Occupation kind of work done du	ion ring most of wor	king 165	. Kind of Business/	Industry		
12	withir ane. than	g L	Elementary/Secondary (0-12) 12	College 0	1-4or 5+)	DO NOT use retired) isewife			1			
	filed withi Hygiene. other than ent, the N		17. Father's Name (First, Middle,		1100		I Mothor's Nam	ne (First, Middle, Maid	own home			
and	ould be f Mental h varkad of	Be	Tr. I allion 3 (Valle) (First, Wildele)	Lasi		unk	io. Mother 5 Nan	ie (Filst, Milodie, Mait	ien Sumame)	unk		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show or other treumatic event, It a Medical Examination in the notified at	ပ္	19a. Informant's Name/Relation	ship (Type Print)	10h Maili	ing Address (Street an	d Number or Pu	ral Pouta Mumbas Ci	huar Taum State 3	Zio Codo)		
Ma	d 2 s th an 7 ls											
	of Health of Hea		Shady Grove Ho 20a. Method of Disposition	spital	20b. Place of Disp	Medical Ce osition (Name of			Location City or			
Baltimore,	Pages nent of I ant: If Ite ury or o		1 Burial 2 Cremation		4 cometany ero	matory or other place)		200	a modelion only of	rown, clato		
ţ	rt Pi		`4 ☑ Donation 5 ☐ Other (S	· · · · · · · · · · · · · · · · · · ·		0.11.	15 %					
Bal	permit. Pages Department of Important: If II any Injury or o		21. Signature of Funeral Service Ronald	S. Wade	Director	2. Name and Address State Ana	tomy Boa	ard 655 W.	Baltimor	e Street		
		- 11	23a. Part1. Exter the disease, of	01010	muce -	Baltimore	, MD 21	.201				
			shock, of eart failure. Lis	t nly one cause on	each line.	ter the mode of dying,	such as cardiac	or respiratory arrest,	Í	Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a D	Monary	embolo	m			minutes		
	/Medical Examiner		resulting in death)	Dué to	(or as a consequence of)		-0.4					
Е		L.	Sequentially list conditions,	b. — Due to	(or as a consequence of):							
	pe sist	Examiner	if any, leading to immediate Cause (Disease or injury	d Due to	(or as a consequence or):							
	and and I-trar	xan	that initiated events resulting in death) Last	c. Due to	(or as a consequence of):							
8760,	cate be executed physician and the burial-transit	a E										
387		dlcal		d								
×	death certific attending p	/Me	IF FEMALE:	23c. If yes, or	tcome of pregnancy				004 0-4-4			
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Fetal death 3[Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year		
o.	the de	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unkr								
Q _	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	P.	Part II. Other significant conditi	ons contributing to a	leath but not resulting in the u	indertving cause given	in Part I.	23e. Did tobaco	a use contribute to	the cause of death?		
Records,	sign d be	d by	Solonic	offertu	Ò			1 ☐ Yes				
Ö	w requir been si should	ete										
3ec	has ye 2 s	Completed	croppes	disease_				24a. Was an autopsy	prior to d	topsy findings available completion of cause of		
a	cate ha	_		pathy				1 Yes 2 □		2 No		
Vital	elclan: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:				h (Check only one)		1000		
of	S in	2	1 Yes 2 No	10	Inpatient 2 EP/Outpatie		4 Nutsing He	me 5 Residence		aty)		
L C	aling Phys	0	1 ☑Natural 5 ☐ Pendi	.9	of Injury 28b. Time o hth, Day Year) Injury	Work?		28d. Describe how in	ilary occurred			
Division	or Attending Phater death. Director; After thin by the funeral	Certification;	3 Suicide 6 □ Could	not be	a at laine. At have a few at		s 2 No	206 1 1 (24 4				
Σ	or A after Direction by	rtif	4 Homicide determ	nined 289. Place	of Injury - At home, farm, st ing, etc. (Specify)	reet, factory, office		28f. Location (Street City or Town, St.		rai Houte Number,		
_	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.		202 Certifica 4 Docate	na Physician: Test	a host of my linear to a	h	4-1-					
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 Certifyi (Check only 2 Medical	Examiner: On the t	e best of my knowledge, deat easis of examination and/or in iner stated.	n occurred at the time, vestigation, in my opin	, date and place, nion, death occur	and due to the cause red at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)		
	o the ithin i	Mec	29b. Signature and tille of certifie		mer stated.	29c. License r	number	294 1	Date signed (Month	Dav. Year)		
	F ≥ F 8		X	1)1	1 -		0148		L 1	11 2000		
				1000	~~~				Trobost	16 2005		
			30. Name and address of person	who completed cau	se of death (Item 23a) (Type,	Print) Russe	II Au	e Gaith	nersburg	md.		
	Sta	te	31. Date filed (Month, Day, Year,	32.1	Registrar's Signature	12/	M 170	<u> </u>	.5.556	,,,		
	Registr	_	0005									

		For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryla	and / Dep	artme	nt of Health and te of Death	d Me	ntal Hy	gien Reg. N	e	are the	2736 3. Time of Dea
Physician /Medica Examine	ı	John Devoe 4a. Facility Name (If not institution, give s ST. AGNES HOSP			4b. Cit	y, Town, or Location of De A LTI MORE	A	Month	+ 1	A .	ear Death	21:15
Funeral Director		5. Social Security Number 6. Sex		rs. last birthday, Yrs.	If Unc Month	er 1 Year If Under 24 H		Date of Bir (Month, Da)9/04/	7193	0 1	Count	ace (State or Fo ry) York
urel; or iteme 23a or 28a-f ehow al Exercimet rust by nutilied at	Director	10a. State 10b. County Maryland N/A		City, Town or L ltimore								1 X Yes 2
De C	2	10e. Street and Number 3320 Benson Avenue			21	ip Code			_	itizen of Wh ted St		
tal Hygiene. d other then "nature!", or iteme 23a or 28a-f ehow event, the Madical Examinational be notified at	by Funer		2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 U.S. 13,	Was Dec	edent of Hispanic Origin? ecry Cuban, Mexican, Pu 200 No Specify:	(Specif erto Ric	y Yes or No an, etc.)		14. Race -		an Indian, etc.
Hygiene. other then "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of V DO NOT	ual Occupation vork done during most of v use retired)	vorking			Kind of Busi		ustry
	o Re Co	17. Father's Name (First, Middle, Last) Joseph Devoe				18. Mother's N	als	n	, Maide	n Sumame)		
7 le trau	1	19a. Informant's Name/Relationship (Typ. Arthur Caliman — H 20a. Method of Disposition	Friend	1	Fre	ss (Street and Number or derick Avenu		altimo	ore,	Mary.	Land	21229
Department of Heal Important: If Item 2 any injury or other once.		1 N Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	emoval from State	New Ca Cemete	matory of thed ry	other place)	/23	/2005	Bal			ryland
ysician Medical Medical Inaminerransit	lical Examiner	23a. Part1. Enter the disease, complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) 3. Use that file conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		tatic sequence of): sequence of):		ncreation					F Ti	Interval Between Onset and Deat
igned by the attending physicien end be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic □ Other (pregnancy specify)				23d. Date (y Day Year
been signed by	2	Part II. Other significant conditions con	tributing to death but not r	resulting in the t	ınderlying	cause given in Part I.			tobacco Yes 2			e cause of death
ste has page 2	Completed						-	24a. Was auto perfo 1 🗆 Yes	psy ormed?	pridea	re autop or to com ath?] Yes	sy findings avail ipletion of cause
is certificate director, pag	e n	25. Was case referred to medical examiner?		1/2-		26. Place of D	Death (C	Check only	one)			
Mer this c	on: to	1 ☐ Yes 2 1 No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year,	ER/Outpatie		OOA Other: 4 Nursing 28c. Injury at Work?				6 Other)
within 24 hours effer death. To the Funeral Director: After this certifica completely filled in by the funeral director, i	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st	M reet, facto	1 ☐ Yes 2 ☐ No ory, office	28f	Location (City or To	Street a wn, Stat	nd Number te)	or Rural	Route Number,
wit in 24 hours effect. To the Funeral Director pletely filled in	Medical	29a Certifier 12 Certifin Physical Chack only 2 Medical Examin	ician: To the best of my lier: On the basis of exam and manner stated.	rnowledge Jeal ination and/or ir	n oreum vestigation	d at the time idate and plu in, in my opinion, death oc	ine, and curred	dus to the at the time,	date an	s) and mann nd place, and	ar as sta d due to	ited. the cause(s)
Tott	2	29b. Signature and title of certifier	3			9c. License number	0		14	ate signed (
10	-	30. Name and address of person who cou	mpleted cause of death (1	tem 23a) (Tvna		AS243852	8		Au	quist	19,2	Lesco 5
State Registra	е	30. Name and address of person who con S. A. (5n) S. S. J. S. S. J. S. S. J. S. S. J. S. S. Date filed (Month, Day, Year) AUG 2. 2. ZUL	32. Pagistrar's Sig	venue	Bal		jla.	J 21			.,	

DHMH 17 Rev 1/2001

DEVOE, JOHN J

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Tine of Death 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marv Theresa 6:03a Dokas 2005 Aug. 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2407 Walden Way Marriottsville Carroll 9. Birthplece (Stete or Foreign Country)
NY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) May 30, 1932 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Davs 1 ☐ M 2 ☐ F 73 085-24-7237 May Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 77 is marked other than "natural", or Iteme 23s or 28e-f show treumatic event, the Medical Examinar must be notified at MD Carroll Marriottsville 1 ☐ Yes 2 X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2407 Walden Way 21104 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 🏋 No If Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Midowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Land Developer/Realtor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Itam 27 is marked oth any injury or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Stockman Helen Marie Purcell ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Donald Dokas (Son/Executor) 4786 Arlington Drive Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 8/19/2005 Sykesville, MD 21. Signature of Funeral Service Licenses Name and Address of Facility HOME & CHAPEL, PA (Box 195) HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 Buan O 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MESENTERIC Immediate Cause (Final Throm Bosis ARTERY lucek Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Dav 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIVERT ICULITIS 1 Pres 2 No 3 Probably 4 Unknown CORDNARY ATERY DISTASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? rule w PolyP 1 ☐ Yes 2 ☐ No 2 🕞 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) tuneral 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident efter death the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide ö To the Hospitei -within 24 hours e To the Funerel D 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature in title of certifier DOO (5144 and address of person who completed use of death (Item 23a) (Type, Print) 9055 CHEUROLET ORIVE ERRY, JR, MD E ELLICOTT CITY, MARYLAND 21043 31. Date filed (Month) State 2 2005 Registrar

		State of Maryland / Der State Unpend Item 23ac27 per me G846		•	9	
Physicia /Medic Examine	al er	1. Decedent's Name (First, Middle, Last) Rita R. Dalcin 4a. Facility Name (# not institution, give street and number) 3530 RESOURCE CT APT 302	4b. City, Town, or Location of Death RANDALLSTOWN	Date of Death Month JUNE 29,	Day Year 2005 3. Time of Death 11:45 A 4c. County of Death BALTIMORE CO	
Funeral Director		5. Social Security Numberunk 6. Sex 1 □ M 2 ▼ F 7. Age (In yrs. last birthda) 74 Yrs. Usual Residence of Decedent	Months Days Hours Min.	Date of Birth (Month, Day, Young 3, 19	930	
	eral Director	MD Baltimore 10c. City, Town or I MD Baltimore Randal 10e. Street and Number 3530 REsourse Court #302 11. Marital Status unk 12. Was Decedent Ever in U.S. 13	1stown 10f. Zip Code 21133		10d. Inside City Limit 1 Yes 2 \(\) \(\	
d 2 should be filed within 72 hours after de th and Mental Hygiene. It and Mental Hygiene. It is marked other than "natural", or item traumatic event. If a Mental Execution.	ted by Funeral	1 Never Married 2 Married 1 Yes 2 No unk 1 Yes Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spect If Yes, specify Cuban, Mexican, Puerto Rin 1 ☐ Yes 2√2 No Specify: edent's Usual Occupation	unk 161	Black, White, etc. Specify: white b. Kind of Business/Industry U.T.	
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permit. Pages 1 and 2 should b Department of Health and Menit Important: if Itam 27 is marked any injury or other traumatic s once.	70 E	O.C.M.E. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	Penn_Street_Baltilik constion (Name of emalory or other place)	re, MD	ity or Town, State, Zip Code) 212()1 c. Location - City or Town, State	
permit. Pa Departmer Important any injury once.		4 Donation 5 Other (Specify) in state 21. Si nature of Fineral Service Livensee Ron 11d S Nade, Firegran	22. Name and Address of Facility State Anatomy Board Faltimore, MD 21201	655 W.	Baltimore Street	
Physician /Medical Examiner with private and private in private in the private in	licai Examiner	shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last Atherosclerotic Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	Cardiovascular Disea	se	Interval Between Onset and Death	
the death certificate y the attending phy sched for use as the	by Physician/Medi		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year	
requires that sen signed b rould be deta	ted by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?	
an: The law tificate has b or, page 2 si	e Completed	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed		
ng Physi Iter this c ineral dire	Certification: To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpati 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be	ent 3 DOA Other: 4 Nursing Home of 28c. Injury at Work? M 1 Yes 2 No	ig Home 5 ☐ Residence 6 ②(Other (Specify) S 28d. Describe how injury occurred		
To the Hospitel or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the to		4 Homicide determined 200. Flade of injuly * Attibute, family, set building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, an	City or Town, S	se(s) and manner as stated.	
To the He within 24 To the Fu Completel	Medical	(Check only one) 2X Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier Calculudal Al. 30. Name and address of person who completed cause of death (Item 23a) (Typ	29c. License number OCME	29d.	Date signed (Month, Day, Year) UNE 30, 2005	
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2, 2, 2005	111 Penn Street	Baltimo	re, Maryland 21201	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year WILLIAM 6:20 a M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner of Catonsville Catonsville Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1⊠M 2□F June 5, Director 244-30-8478 80 1925 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1502 Frederick Road 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race · American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black Completed by 3 ☐ Widowed 4 🏝 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown maintenance Baltimore Co. Gov. other traumatic event. 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depurtment of Health and Mental Hy Inportant: If Item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Gaither/cousin 2208 Chelsea Terrace Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 ☒ Other (Specify) 1n State 21. Signature of Funeral Service Licensee Rona Let S. Wade State Anatomy Board 655 W. Baltimore Street Director un Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Chronic Physician 71. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit been signed by the attending physician and should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 2 No 1 Yes 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? · 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident hours after death thei 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) August 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1009, frederick Rd. Cotorsille, My B. TURAKHIA, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 2 0 2005

		1. Decedent's Name (First, Middle, I	em 8 per FH,				2. Date of D		-00,	3. Time/of Deal	
Physic /Med		Catherine Ellis	sthorpe				July		005	8:25 AM	
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* 12		Usual Residence of Decedent 10a, State 10b, County	1	0c. City, Town or I	Location					10d. Inside City Lim	
sho	ō	MD Anne A		Annapoli						1 □ Yes 2/□	
286	Director	10e. Street and Number	I dilde!	Aimapot	10f. Zip Code			10g. Citiz	zen of What Co	ountry?	
3a o		632 Tripp Creek	Court		214	01		USA			
E PA	Funeral	11. Marital Status unk	12. Was Decedent Eve Armed Forces?	er in U.S. 13	B. Was Decedent of If Yes, specify Cul		? (Specify Yes or N		14. Race - Ame Black, Whit		
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- 4 -		Tony Viceconte/			Tripp Cre	eek Coui		lis,	MD 2140)1	
of H		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 1 □ Donation 5 🖾 Other (Spe	Removal from State	20b. Place of Dis cemetery, cr	position (Name of rematory or other pla	(ace)	Date	20c. Lo	cation - City or	Town, Stete	
Department Important: any injury	Buck	21. Signature of Funeral Service Lice Ronald S	// /	tor §	22. Name and Addr State Anat	tomy Boa	ard 655 W	. Bal	timore	Street	
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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** orma Farnande Hugust /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Columbi If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec 3, 192 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 😿 F 217-16-8638 Yrs Director <u>Indiana</u> Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "natural", or Iteme 23a or 28a-f sho tre Medical Examiner must be notified at 1 ☐ Yes 2 TNo Carroll Sykesville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Springfield Hospital Center Funeral 21784 filed within 72 hours after death USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. I ☐ Yes 2√☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: δ Specify: White 3 Widowed 4 🙀 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cosmetologist Beauty Care marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Herman E. Waggoner Laura L. Taransky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum once. Mrs. Helen Will (Sister) 6273 Wild Swan Way Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Memorial Gard.8/17/05 4 □ Donation 5 □ Other (Specify) Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Bo Sykesville, MD 21784 (410)-795-1400 PA (Box 195) 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician DOXICO /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy lindings available prior to completion of cause of death? s certificate has b lirector, page 2 si 2∏ No 1 Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient ۵ 1 Yes 2 No 2 ER/Outpatient 3 DOA this Alter this 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 1 Yes 2 No investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D50870 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bell lane Claribulle in Bdo 5005 Surant Signa 31. Date liled (Month, Day, Year) 32. Registrar's Signature State AUG 2 2 2005 Registrar Goods

			For State	State of Ma	ryland	•	urtment of F tificate of		Mental Hy	gien Reg. N	0000	070-	
	余		Registrar Decedent's Name (First, Middle, Later)	st)			imodio oi	Dodin	2. Date of De	ath	- La College	3. Time of Death	
	Physici /Medio		Geraldine	Ρ.		Fi	sh		August	21	ľ, 2ď05	4:20 A.M	
	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	r Location of Dea	th	40	c. County of Death		
			4002 Washington					ltimore			N/A		
	Funeral Director		5. Social Security Number 6. S 217-38-8078 1 Usual Residence of Decedent	DM 2FF	(In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 Hr: Hours Min		, 19	941 Mar	place (State or Foreign htry) yland	
	land ow		10a. State 10b. County		10c. City, T	own or Lo	cation				1.	10d. Inside City Limits	
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	h the	Directo	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	ntry?	
	23a c	aiD	4002 Washington S	treet			2122	7			U.S.A	•	
36	n 72 hours after death with the Maryland "netural", or iteme 23a or 28a-f show idical Examiner must be notilled at	by Funeral	11. Maritaf Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give			Vas Decedent of H Yes, specify Cubi	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	>-	14. Race - Americ Black, White, Specify: 171	etc.	
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g	m 0 5	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	, Maidei	n Surname)		
<u>a</u>		To	George	Louis		Seibe	1	Eva			.,	Glowacki	
Maryland 21	2 E = 1		19a. fnformant's Name/Relationship (or Town, State, Zip	Code)	
	s 1 and 3 of Health item 27 other tra		Diana L. Olup (Da	ughter)			Oak Road		re, Mary				
Baltimore,	Pages nent of ant: If it ury or o		20a. Method of Disposition 1 ☑ Suriaf 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	y)		Have	sition (Name of natory or other place n Mem. Pl	k. 8/2	4/05	Gler		Maryland	
39	permit. Departr Importa any inji		21. Signature of Funeral Service Licer	1500		²² M	CCuIIy-P	ss of Facility o Lyniak	Funera <u>l</u>	Ноте	e, P.A.	yland 21225	
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58760,	phy:	edicai		d									
O. Box	death certi	Physician/Me	fF FEMALE: 23b. Was decedent pregnant in the past 12 moeths? 1 □ Yes 2 ②No 9 □ Unknown	23c. If yes, outcome of the complete of the co	2 ☐ Fetal de	ath 3	Ectopic pregnancy Other (specify)	,			23d. Date of delive Month	Day Year	
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ō	± E	. To	27. Manner of Death	1 fnpatier 28a. Date of Injun	/ 28	b. Time of	28c. Injur	4 Indising	dome 5 Resident		6 ☐Other (Specify occurred	/)	
lo I	Attending I ir death. ector: After by the funer	atio	1 ☑Naturaf 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day	Year)	fnjury		k? Yes 2 □ No					
Division	s after death	Certification:	3 Suicide 6 Could not be determined	28e. Pface of Inju building, etc.	ry - At home (Specify)	, farm, stre	eet, factory, office		28f. Location (City or Tou	Street ai	nd Number or Rura e)	l Route Number,	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in E	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysicien: To the best o niner: On the basis of and manner stat	exa <i>m</i> :nation	dge, death and/or inv	occurred at the tirestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s date an	i) and manner as st d place, and due to	ated. the cause(s)	
	Tot Tot	Ž	29b. Signature and title of certifier	thety	9		29c. Licens	e number	7	29d. Da	ate signed (Month,	Day, Year)	
	10		30. Name and Address of person who	completed cause of de	ath (ftem 23	Ba) (Type, I	Print)	- 392	7 111	JAI	polis Re	d BAHO.	
A	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	-	- 10 -				7.5	21227	
Š	Registr	-	AUG 2 2 2	005 Blow	w B	D							
DH	MH 17 Rev 1/2	001				6"							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 700 Month Day Vear Featherstone **Physician** Annie 20 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Paltimore Home wood Care, If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthdey) 83 Yrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral 1 M 2 XF 220127417 4-14-22 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental hygiene.

Int if item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD. 1 Yes 2 □ No Baltimore **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number USA Street 718 E. 21218 . Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 No Specify: Specify: Bach Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) tome a 12H m 17. Father's Neme (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Sumame) Be ameron ဂ္ , 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 718 E. 23rd St. Dou lena Baeto, md, 21218 20b. Place of Disposition (Neme of cemetery, cremetory or other place) ortant If item ? 20c. Location - City or Town, State 20a. Method of Disposition Dete / 1 ☐ Burial 2 ☐ Sremation 3 ☐ Removal from State 122/05 CrematoRy 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 3405 W. Mancy m. wallace Fineral Service Batto. nd, 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical End Stage Examiner Physician/Medical Examiner for Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Due to (or as a consequence of): P.O. I Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? H/o Colon Cancer; 140 Corels 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed by 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was en autopsy performed? 1□ Yes 200No 1 Yes 2 YNO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Vertifying Phyelclan: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medical (Check only one) 29c. License number 0 17537 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAR SHAN'S SALYA (600 W. MOUNT ROYAL AM, B. 15 21217

State Registrar 31. Date filed (Month, Day, Year)



Speciel

State of Maryland / Department of Health and Mental Hygiene

				State of W	arylanu / L	Certificate of		Re	a. No. O O E	7 /9 109			
			Decedent's Name (First, Middle,	Lest)				2. Date of Deeth		3. Time of Death			
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7	/Medic Examin	_	4a Fecility Neme (If not institution,	give street end number)			4b. City, Town, or Lo		4c. County of Dea	th			
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	Director		173-05-4259	1□ M 2 F	95	Yrs.		Aug 14,	1910 Pe	nnsylvania			
	p ,		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow	n or Location				10d. Inside City Limits			
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20	irs af	ρ	3 ☑ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: V	vhite			
Ö	filed within 72 hours aftar death with the Merylend Hygiene. ther than "natural", or items 23s or 23s-f show ther than Medical Examiner must be notified at	Completed by	15. Decedent's	Educetion	16a	Decedent's Usual Occup (Give kind of work done	ation	ring 1	16b. Kind of Business	/Industry			
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/la	ould b Ments marked	2											
Maryland 21215-0020	parmit. Pages I and 2 should be filed within 72 hours aftar death with the Merylen Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationshi	p (Type, Print)	198	. Mailing Address (Street	and Number or Run	el Route Number,	City or Town, State,	Zip Code)			
	and ealth n 27		Walter Fleische	r/son	5	625 Bright D f Disposition (Name of	awa Court	Columbi	la, MD 21	045			
Baltimore,	of H of H fiter or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	B⊟Removal from State	comete	ry, crematory or other plac	сө)	Date 2	20c. Location - City or	rown, State			
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Salt	parmit. Departi importu any inj pnce.		21. Signature of Funeral Service Line Ronald S	ensee Wade, Dir	ector	22. Name and Addre	ss of Facility Omv Board	655 W.	Baltimore	Street			
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ord	en si ould	2	HYPOTHYA	Neinism				24a. Was ar perform		Were autopsy findings available prior to completion of cause			
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<u>m</u>	0 - 0	Completed						10.40	5 20 2 110	1 ☐ Yes 2 ☑ No			
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E C	iing Phys n. After this funeral d	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, De	ey Year) 28b.	Time of 28c. Injury Wo	ryat rk? ∣Yes 2.⊠No	28d. Describe no	w injury occurred				
Sig	tend leath tor: /	cat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	t be	iun. At homo f	erm, street, factory, office	163 2010	28f. Location (St	reet and Number or R	łural Route Number.			
Division of Vital	or Ar	Certification:	4 ☐ Homicide determin	building, e	tc. (Specify)	, street, rectory, critical		City or Town					
_	spitai lours serai filled	C				e, death occurred et the til							
	Hot 124 h	edicai	(Check only 2 Medical Ex	kaminer: On the basis of end manner st		nd/or investigation, in my o	ppinion, death occur	red at the time, da	ate and place, and du	e to the cause(s)			
	To the Hospital or Attending Physi within 24 hours after death. To the Funeral Director: After this of completaly filled in by the funeral director.	Z	29b. Signature and title of certified	20 and 1		29c. Licens	30469	7	9d. Date signed (Mon	th, Dey, Yeer) 5, 2005			
			M. K. E.			10.	20401		ingus! 1.	-, 20-2			
			30. Name end address of person w	ho completed cause of	deeth (Item 23a)	(Type, Print)	Micott	1.7	and nu	11/2			
			Mandakum	ac 10.	ellar	ike E	more	cuy 1	ny 2/0	72			
*	Sta		31. Dete filed (Month, Day, Year) AUG 2 2	2005 32. regist	rer's Signature	Sparke		/					
	Registr	ai .	700 2 2	- SOUL	Carl Jus								

		For State Registrar	i icase i	State of M		d / Dep		t of H	ealth a		ental Hy	giene		e.	
		Hegistrar Decedent's Name	(First, Middle, Last)				rincat	e or i	Jeani		2. Date of De	Reg. No.	.00	5-12	3 Time of Disaffer
Physi		Frede			uss						Month August	Day	2005	ear	4:30p M
/Med Exam		4a. Facility Name (If I	not institution, aive	street and number)		4b. City.	Town, or	Location of	f Death	Nuguse		County of		4.30p
LAdii	mei		e Hill Co						ttsvil				rrol1		
Funera		5. Social Security Nu			ge (In yrs.	last birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Bir	th			e (State or Foreign
Directo		219-32-960		^{M 2□F} 68		Yrs.	Months	Days	Hours	Min.	(Month, Da Dec 8			MD)
pu .		Usual Residence of I	Decedent 10b, County		10c Cit	ly, Town or L	nantian							1404	In the Objection
ath with the Marylar 23e or 28a-f ahow ust be molified all	5		Carrol1			Marriot		11e							Inside City Limits 1 ☐ Yes 2 ☐ No
the N	ect	10e. Street and Num										40- 00			Λ
with	Ë		e Hill Co	nırt			10f. Zip					USA	zen of Wha	it Country	f
5-0036 To hours after death with the Maryland natural", or Itams 23e or 28e-f ahow alcal Examination at	Funeral Director	11. Marital Status		12. Was Decedent	Ever in U	S. 13			spanic Oric	nin? (Spe	city Yes or No		14. Race -	American	Indian
136 rs after dea l', or itams	표	1 Never Marrie		Armed Forces 1 M Yes 2 ☐ If Yes, Give	?				n, Mexican	Puerto F	cify Yes or No Rican, etc.)			White, etc.	
030 ours a	by	3 ☐ Widowed 4		If Yes, Give Year or Dates:	1)		1 🗆 Yes	2 X No	Specify:				Specify:	white	e
15-003 172 hours "natural",	Completed	(Specif	15. Decedent's Edu y only highest grad	cation a completed)		16a. Dece	dent's Usua	al Occupa	ation furing most)	of working	20	16b. Ki	nd of Busir	ess/Indus	try
21215-0036 od within 72 hours afr gjene. ar than "naturat", or . Ire Maxical Exact	lg.	Elementary/Secon		College (1-4or	5+)							_	_		
nd 212: a filed within I Hygiene. other than		10				gas	stati	ion (erator				
be find Hall Hall Hall Hall Hall Hall Hall Hal	Be	17. Father's Name (F									(First, Middle,	Maiden	Sumame)		
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Maryland id 2 should be file th and Mental Hy th is marked othit traumatic avant.		19a. Informant's Nar Bettie Ga									Route Numberriotts				
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DO DE SE SE SE SE SE SE SE SE SE SE SE SE SE		1X□ Burial 2 □	Cremation 3 P	lemoval from State		Place of Disposemetery, cre									
Baltimore, permit. Pages 1 ar pepartment of Heal mportant: If item any injury or other		4 □ Donation 5	Other (Specify)		Lak	e Viev				3-22-			svill		
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		23a. Part1, Enter the	disease, or compl	cations that cause	d the deat	h. Do not en					ville,		21/84	Ac	oproximate
		shock, or heart Immediate Cause (F	failure. List only or	ne cause on each	ine.							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ln1	terval Between nset and Death
Physician /Medica	_	disease or condition resulting in death)		Due to (or as			acem	401	ally					-	2 years
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outed Id ansit	Examiner	Cause (Disease or in that initiated events	njury												
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0 5 0	cal			d											
9 plas	Med	IF FEMALE:													
Box auth cert attendin for use	by Physician/Med	23b. Was decedent	pregnant	3c. If yes, outcome 1 ☐ Live birth			⊒Ectopic pr	regnancy				1 :	23d. Date o		
O. BC ne death the atter hed for u	Sici	in the past 12 m		4 ☐ Pregnant a 9 ☐ Unknown	it time of d		Other (sp						Month	Da	y Year
by T	Phy	9 Unknown									11				
igned be det		Part II. Other signific	ant conditions col	tributing to death	out not res	uiting in the t	inderlying c	ause give	en in Part I.						eause of death?
cords, w requires been sign should be	eted										1	res 21		Probably	y 4 🗂 Unknown
do a a co	Completed	<u></u>									24a. Was autor	SV	24b. Wei	e autopsy r to compl	findings available etion of cause of
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of Vital F Physician: Th this certificate ral director, pag	Be	25. Was case referre examiner?		I i - I -							(Check only o				
of Vi Physicia this cert al direct	2	1 ☐ Yes 2 ☐	lo l			ER/Outpatie		Othe Othe	er: 4 □ Nur		ne 5⊡ Resi			Specify)	
Ing ing when	lon:	27. Manner of Death 1 Natural	5 Pending	28a. Date of Inj (Month, D.	ay Year)	28b. Time o Injury		28c. Injury Work	(?		8d. Describe I	now injur	y occurred		
Vision r Attending er death. rector: After by the fune	icat	2 Accident 3 Suicide	investigation 6 Could not be	Office of the	iliuma Aalm		М		Yes 2□N		104 f	24	-d & d	0 10	
Division Tor Attending after death. Director: Afte	Certification:	4 Homicide	determined	28e. Place of Ir building, e	tc. (Specif	y)	reet, ractory	у, опісе		-	8f. Location (3 City or Tox	vn, State))	or Hurai Ho	oute <i>Number</i> ,
spita ours naral filled		29a. Certifier	1 Certifying Phy	sicien: To the best	of my kno	reah enhelwr	h occurred	at the tim	a data and	t place o	nd due to the	nauea/a\	and man=	N 20 clat-	d
To the Hos within 24 ho To tha Fun completely	edical	(Check only one)	2 ☐ Medicel Exami	ner: On the basis and manner s	or examina	ation and/or in	vestigation	, in my op	oinion, deat	h occurre	d at the time,	date and	place, and	due to the	e cause(s)
To the within To the comple	≥	29b. Signature and t	itle of certifier				290	c. License				29d. Dat	e signed (A	fonth, Day	v, Year)
F S F S		D Orac	els M	0				0 (203	5		Λ	icist	20	2.11
10		30. Name and addre	ss of person who co	moleted cause of	death (Iten	n 23a) (Tyre	Print\	V)				(ינוין		
0				91 Stone	~ /	J. 12	,	We	203	Ister	, 1	10	2/157	_	
	tate	31. Date filed (Month		32. Re	rar's Signa	ature	A .								
Regis	strar		MUG 2 2 2	AND AND	low	15	Gosses	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGUST ET, 20185 2:30 A M Donald A. Goldman /Medical 4a. Fecility Name (If not institution, give street and number) Saint Joseph Medical Center 4c. County of Death Baltimore 4b. City, Town, or Location of Death **Examiner** Towson 8. Date of Birth (Month, Day, Year) May 31, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 1 € M 2 □ F Days Months Hours 215-30-6456 71 Director 1934 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f ehow 7 ie marked other than "neturel", or Items 23e or 28e-f ehov traumatic event, the Medical Examitrat must be i Adithed at Md. Baltimore Phoenix 1 ☐ Yes 2 ¥ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13904 Sunnybrook Rd. 21131 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than ' Elementary/Secondary (0-12) College (1-4or 5+) President Fitness 12 should be filed w h and Mental Hygier 7 Ie marked other th 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Goldman Yetti Sandler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an 13904 Sunnybrook Rd. Phoenix, Md. 21131 Mrs. Sheila Goldman/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Importent: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 8-22-05 Towson, Md. 21. Signature of Furneral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc 23a. Part1. Enter the diseate, or confull ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Single Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician ACUTE GASTROINTESTINAL BLEED disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner HEPATIC ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine been signed by the attending physician and should be detached for use as the burial-transit Attending Physicien: The law requires that the death certificate be executed CIRRHOSIS OF LIVER resulting in death) Last Due to (or as a consequence of): HEPATITIS C Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient Certification: To 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide l or A within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) La M. D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. 7601 OSLER DRIVE TOWSON MARYLAND MEHTA 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 2 2 2005

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

			For State	State of Ma	aryland / Depa			Mental Hyg	iene	
		_	Registrar 1. Decedent's Name (First, Midd	la Lasti	Ce	rtificate of l	Death	2. Date of Deat	og. No. 200	5 27371
	Physicia		Robert Gara					August		ear 1412 M
)	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, or	Location of Death		4c. County of	Death
		٠		ospital			Stown	1	Ralti	
	Funeral Director		5. Social Security Number 250-40-8729	6.16ex 7. Age	(In yrs. last birthday)	Months Days	Hours Min.	8. Date of Birth	130 3	Birthplace (State or Foreign Country)
	D	-	Usual Residence of Decedent		10a City Town as la			17110	100	
	daryla f shov	ō	10a. State 10b. County		10c. City, Town or Lo	on Oak	,			10d. Inside City Limits 1 XYes 2 □ No
	death with the Maryland ms 23a or 28a-f show rmat be collined at	Funeral Director	10e. Street and Number	0		10f. Zip Code		10	0g. Citizen of Wha	at Country?
	ath will	ral D	6111 Talles	Road		216	207		45	A
	ter deg	une	11. Marital Status 1 ☐ Never Married 25 Mar	12. Was Decedent E Armed Forces? ried 1 X es 2 □ N		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
9500-612	hours after turel', or Ite al Examina	by	3 ☐ Widowed 4 ☐ Divorced	If Yes. Give		1 ☐ Yes 2 No	Specify:		Specify:	3lack
<u>.</u>	"natur	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	(Give	dent's Usual Occupa	luring most of wor	rking	16b. Kind of Busin	iess/Industry
7.1.7	filed within 72 Hygiene. Ither than "nai Int, the Medic	omp	Elementary/Secondary (0-12)	College (1-4or 5-	+) life.	PONOT use retired	,		Bethle	hom Steel
and	m = 0 %	BeC	17. Father's Name (First, Middle,	Last)			_	ne (Fiest, Middle, A	laiden Sumame)	7.011
\leq		70	Yeter ba	rrett	190		tatsy	Collin	aton	
Mar	S a s		Aa. Informant's Name/Relations	ship (Type, Priti)	a [19b. Mailir	ng Address Street a	PJ C	ral Route Number	Oty or Town, Sta	ite, Zip Code)
J.	of Health item 27		20a. Method of Disposition	277	20b. Place of Dispo	osition (Name of matory on other place	9)	Date /	20c. Location - Cit	y or Town, State
aitimore,	Pages ment of tent: If it jury or o		`4 □ Donation 5 □ Other (\$			w Memo		22/05	Sylvesi	rille, mb
Rail	permit. Pages Department of I Importent: If it any injury or o		21. Signature of Funeral Service	Licensee) 2	Coughade		ed Fune	alser Millston	vices' un Ond 21133
			23a. Part1. Ente the disease, o shock, or he failure. Lis	r complications that caused tonly one cause on each lin	the death. Do not ent	er the mode of dying			The state of the s	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. Pneu	monia					Onset and Death
	/Medical Examiner		rodaling in doubly	Due to (or as a	a consequence of):					
		ner	Sequentially list conditions,	b. Due to (or as a	consultience of):					
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (os se	a consequence of):					
8/60,	cate be executed physician and the burial-transit		,	Due to (or as a	a consequence or).					
9	tificate ig phys as the	ledical		0.						
ROX	death certifi e attending p ed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal death 3	Ectopic pregnancy			23d. Date of Month	f delivery Day Year
	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of death 5	Other (specify)			1	Day 10a
7	res that the de signed by the a be detached to	by Ph	Part II. Other significant conditi	ons contributing to death bu	ut not resulting in the u	nderlying cause give	an in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
ords	w require been sig should b	ted t						1 ☐ Ye	s 2 No 3	Probably 4 Unknown
Vital Records,	has has	Completed						24a. Was ar autopsy perform 1 12 Yes 2	ried? prior deat	
II.a		Bec	25. Was case referred to medica examiner?					th (Check only one		Yes 2□No
01	this at di	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 🗷 Inpatier			4 🗆 Nursing 🗆	ome 5 Reside		Specify)
	th. th. After funera	tlon	1 Kanatural 5 ☐ Pendi		y Year) 28b. Time of Injury	Work	at i? /es 2 □ No	28d. Describe ho	w injury occurred	
DIVISION	of or Attendate death Director: /	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		Iry - At home, farm, str	reet, factory, office		28f. Location (Str. City or Town,		or Rural Route Number,
5	urs aft urs aft erel Di		~							
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner sta	examination and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
\	withi To t	Σ	29b. Signature and title of certifie	001:	10	29c. License	6369		d. Date signed (N	
4	54		30. Name and address of person	believed cause of de	ath (Item 23a) (Type.	Print)	1 10		ugusi 1	7,2005
	~		Deborah Belchi	3 5401 old	lourt Ro	ad Rano	vallstou	un Mai	yland	
	Sta Registr		31. Date filed (Month, Day, Year, AUG 2	who completed cause of de 3 5401 Old 32. Registra 2 2005	w A A	porte				
					-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Year Month **Physician** 005 ARTHUR GRIFFIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner andallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 18**X**M 2□F 231-30-5576 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County show r than "naturel", or items 23e or 28a-f shov the Medical Examinant De notified at 1 Yes 2 0 Funeral Director more 10g. Citizen of What Country? 10e. Street and Numbe 21133 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Blac Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ith and Mental Hygiene. 27 le marked other than "r r treumetic avent, the Med Elementary/Secondary (0-12) College (1-4or 5+) vor Ke 18. Mother's Name (First, Midelle, Maiden Sumame) ather's Name (First, Middle, Be Pages 1 and 2 should be to nent of Health and Mental I out; If item 27 Ie marked o (gr ဂ te Number, City or Town, State, Zip Code) other Method of Disposition

1 ■ Burial 2 □ Cremation 3 Removal from State Department o Importent; If eny injury or once. ŏ Himore, Donation 5 Other (Specify) nature of Aneral Service Lie Approximate Interval Between Onset and Death 23a. Part1. Bush the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner GASTROLINIESTIMAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine buriai-transit IRRHOSIS OF Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nuknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 🗆 No To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 1 ☐ Yes 2 No 10 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 2 No 1 🗌 Yes investigation after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funerel C 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier relia mo

DHMH 17 Rev 1/2001

State Registrar HURTH WEST

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 GINDER PMEHTR

CENTER

32. Regis ar's Signature

HOSPITAL

AUG 2 2 2005 >

D41410

RANDAUSTOWN MD

August

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2005

			1 - For State Registrar	State of Ma	aryland	-	artmen rtificat				lental Hy	giene	005	273	376
	Physici		1. Decedent's Name (First, Middle, La Fleta Rolene		2						2. Date of D Month August	aath	2005	3. Time o 7:13	P M
	/Medi Examir ————— Funeral		4a. Facility Name (If not institution, given University of Mary 5. Social Security Number 6.5	vland Medio		enter		altin	Location NOTE			4c. C	ounty of Death		or Foreign
	Director		384-16-2636 Usual Residence of Decedent	□M 2 5 4F	82	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D Feb. 1.	2, 1923	Bel	intry) levue,	
	a-f ehow	ctor	MD 10b. County Calver	t		Town or Lo								10d. Inside C	ity Limits
	th with th 23a or 28 rat be no	Funeral Director	10e. Street and Number 1488 Flag Harb	or Blvd.			10f. Zip	Code 2068	35			10g. Citize	on of What Col	intry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any follury or other traumatic event, if a Medical Examination institute prelified at Angles.	ğ	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If If Yes, Give Year or Dates:		1	Was Deced f Yes, spec 1 ☐ Yes		ispanic Or in, Mexica Specify		ecify Yes or N Rican, etc.)		l. Race - Amer Black, White pecify: W		
21215-0036	d within 72 h giene. Ir then "natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12		+)	16a. Deced (Give life. L	kind of wo DO NOT us	rk done d	during mos)	st of work	ing		of Business/li m Home	ndustry	
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	and 2 should salth and Men n 27 le marke ler traumatic		19a. Informant's Name/Relationship (Ed Sefton/Son	Туре, Print)									ND 206	,	
Baltimore,	Pages 1: ment of He ant: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 反 4 ☐ Donation 5 ☐ Other (Specif		Ce	ace of Dispo metery, crem le Grow	natory or o	ther place	ө)		Pate 9/05		ition - City or T	own, State	
Balt	Departr Departr Importe any Inju		21. Signature of Puneral Service Licer	1588		22		les I	. Ster	vens I	uneral H Baltimor				
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P.O. Box 6	t the death certific by the attending p tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ØNo 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal o	death 3□	Ectopic pro					230	d. Date of deliv	•	Year
	quires that an signed l	۵	Part II. Other significant conditions of	ontributing to death bu	it not resul	ting in the ur	nderlying ca	ause give	on in Part I			obacco use Yes 2	contribute to t	he cause of d bably 4 □t	
al Records,	i: The law requicate has been r. page 2 shoul	Completed											24b. Were auto prior to co death? DELYes	mpletion of c	available ause of
Vital	siclan: certific rector.) Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Impatier				Othe			Check only				
ō	Physer this eral di	ت. 5	27. Manner of Death	28a. Date of Injur	v 2	R/Outpatient 28b. Time of		8c. Injury	at	irsing Hor	ne 5∐ Resi 28d. Describe	how injury o	Other (Special		-
ion	nding I ath. r: After e funer	ate	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury 4 5 4 7	р М	Work 1 □ Y	? ∕es 2.0≸		doner	of n	notor un	enre	,
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At hom . (Specify)	ne farm stre		, office		1	_ City or To	Street and f vn, State)	Number or Run	ek Kd	ber,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on niner: On the basis of and manner state	examınatio	ledge, death on and/or inv	occurred a restigation,	at the tim in my op	e, date an inion, dea	d place, a	and due to the ad at the time,	cause(s) ar date and pl	nd manner as s ace, and due t	totad)
	To the To the Comp	Σ	29b. Signature and title of certifier				29c.	License				29d. Date s	igned (Month,	Day, Year)	
)	~		Janto 3	eefn	is			0.	C.M.	Ε.		Augus	st 20,	2005	
-	0		30. Name and address of person who	1 .											
			10Sha ZGYEE 31. Date filed (Month, Day, Year)	n Derg M 32. Faststra	. D.	100	-		et, l	Balti	more,	Maryla	and 212	01	
	Sta Registr		AUG 2 2			B. A	borte	,							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 0.3 **Physician** 20 Joshua Ganu 2005 9:12A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** X M 2□F Yrs. 3/20/2005 Director None Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 ☐ No Director MD Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with or Items 23e or S • A • 14. Race - American Indian, 1217 Dahlia Ln. 21703 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event. Ransford Ganu Magnira Ganu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Magnira Ganu/Mother 1217 Dahlia Ln., Frederick, MD 21703 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. W. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Extreme Prematurity /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Il-transit Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-1 Box 68760 Physiclan/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2X No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 9 1 ☐ Yes 2X No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After or Attending 1 XNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation M 2 Accident the 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Momicide within 24 hours a

To the Funerel D

completely filled i To the Hospitel 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 0023 Naua oun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Phillip Dr. 20832
32 Aegistrar's Signature Nancy P. youssefi State Registrar

JC			State of Maryland / Department of Health and Me	ental Hyd	iene	
Emily	M. Har	ri	State of Maryland / Department of Health and Message Unpend Item 23a,27,28a-f per me 6846, 8-31-05 tas	P. C. C. C. C. C. C. C. C. C. C. C. C. C.	eg. Na2 0 0 5	27378
				2. Date of Dea	th	3. Time of Death
	Physicia		Emily MARIE HARRIS	August	17 2005	20:45 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	h
			St. Agnes Hospital Baltimore		NA	
0	Funeral		Months Days Hours Min	8. Date of Birth, Month, Day,	(Year) 9. Birt	hplace (State or Foreign
7	Director		2/7-80-5085 1 M 2/8 33 Yrs. William 2/8 Yrs.	zeptemb	EL 24, 1981 HA	ey land
	land		10g. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Many	to	MARYLAND NA BAHIMORE			1 Yes 2 □ No
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	th will	Funeral Director	3212 Normaint Ave 2/2/6		USA	
	tems	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Research of Hispanic Or	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte	by Fi	1 Never Married 2 Married 1 Yes 2 No II Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates:		Specity:	AMERICAN
윽	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23a or 28a-f ehow ont, the Medical Examinar must be notilified at		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	
215	nin 72	plet	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	ng		
212	d with giene er the	Completed	12th Stone Clerk		7-11-57	GRE.
p	2 should be filed within and Mental Hygiene. te marked other than aumatic avent, the M	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle,	Maiden Sumame)	
<u> </u>	should bind Ment	2		Racks		
Jar	2 sh and te m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural MARY SACKSON - MOTHER 827 AP (1944) AVE			Zip Code) 2/2/6
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: if item 27 ie marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avent, the Medical Experiment must be notified at once.				20c. Location - City or	Town State
Jo.	nt of l		Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) August	23205	LAUSDONE	
튵	permit. Pag Department Important: any injury o					
Ba	Dermi Depa Impo any i		21. Signature of Funeral Service Licensee 22. Name and Address of Facility UARCACE	Funer	AL SERVICE	mr. 1. 2/2/9
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final			Onset and Death
	/Medical		disease or condition resulting in death) NATCOLIC INTOXICATION (MORPHLINE AND M. Due to (or as a consequence of):	icciadoi	iic)	
	Examiner		Sequentially list conditions			
	ם ב	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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×	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of del	ivery
m.	death e atte	lcla	in the past 12 months? 1		Month	Day Year
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ś	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as it	Þ	Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
oro	requi	Completed				obably 4 Unknown
ec Sec	e law hes b	nple	*	24a. Was a autops	sy prior to o	topsy findings available completion of cause of
<u>=</u>	sician: The lav certificate hes rector, page 2			1 Yes	2□No 1XYes	2□ No
<u> </u>	sicial	o Be	25. Was case referred to medical examiner? 1 △ Yes 2 □ No		ence 6 ⊡Other <i>(Spe</i>	- 4.)
o,	Phy ar this eral d	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28		ow injury occurred	unk
<u>.</u>	Attending r death. ector: After oy the fune	atlo	1 Natural 5 Pending Format Day Year) Format Work? 2 Accident investigation 8-17-05 6:51 PM 1 Year 2 No			
Division of Vital Records, P.O. Box 6	r Atten er dea rector: by the	Certification;	a Tip I Could not be	8f. Location (SI City or Town	treet and Number or Run, State) 4111	pringdale Av
É	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		Scene	Baltimo:	re, Md	
18 Ja	the Hospital nin 24 hours the Funeral npletely filled	ical	29a. Certifier (Check only Check only Check only Check only Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	and due to the ca	ause(s) and manner as late and place, and due	stated. to the cause(s)
10 4	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number		9d. Date signed (Monta	
	F.≅ F. 8		7ah illal (Al- O.C.M.E.	1	August 18,	-
	4/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
			7ABIUUAH AY 111 Penn Street, Baltimore	e, Maryl	Land 21201	
	Sta		31. Date filed (Month, Day, Year) 32. Segistrar's Signature			
	Registr	ar	AUG 2 2 2005 Januar 15 1900			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 9 per th 8847 9-1-05 vt

		•	For State Registrar	State of Ma	tryland /	Department of F Certificate of			jiene 	5 27379
	Physicia	an	1. Decedent's Name (First, Middle					2. Date of Dea Month	th Day Ye	3. Time of Death
o.	/Medic	al	Phillip Hanl 4a. Fecility Name (If not institution			4h City Tourn	r Location of Deatl	AUGUST	4c. County of D	
1	Examin	er	1288 RITCHIE HV			ARNOLI				RUNDEL CO
ľ	Funeral Director		5. Social Security Number 115-62-4329	6. Sex 7. Age XIXIM 2□F	38	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 08/10/	Year) ⁹	Sinthplan (Slage or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City. Toy	vn or Location				10d. Inside City Limits
	death with the Maryland ome 23e or 28e-f ehow If must be notified at	to		Arunde1	Arno1					1 Yes 2 No
	or 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	t Country?
	ath wi	ral	1288 Ritchie			21012			USA	
36	within 72 hours after de ene. than "natural", or Item to Musical Exactinal I	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ ※ Marrial 3 ☐ Widowed 4 ☐ Divorced	If Vas Give	Ever in U.S. Io	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A Black, V Specify: [umerican Indian, Vhite, etc. Vhite
2-0036	"natural		15. Deceden	t's Education	16a	. Decedent's Usual Occup	pation		16b. Kind of Busine	
7	ithin 7	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4or 5	+)	(Give kind of work done life. DO NOT use retired	during most of word)			
Maryland 21	filed w Hygier Ather th		12 17. Father's Name (First, Middle,	Lasti	Pι	irchasing A		ne (First, Middle,		ce Engineeri
<u>a</u>	d ta b	To Be	James Carmody					a Osbor		
ary	should and Men is marke		19a. Informant's Name/Relations	hip (Type, Print)	1	b. Mailing Address (Street	and Number or Ru	ıral Route Numbei	r, City or Town, Stat	
	s 1 and 2 f Health item 27 l		Debra Han	lin (wife)		00 Indian	Camp Ro			
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2/Dremation 4 Donation 5 Other (S	(pecify)	cemete	ory, crematory or other plac upeake Crem	natory (08/13/20		sville, MD
Ball	permit. Pag Department Importent: I any injury o		21. Signatur of Funeral Service	Hemming	0	2222 IMI	n Knoll	s Kd.	Columbi	omes, Inc. a, MD 21045
ī			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lir	10.			/	//	Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aOUQ Due to (or as	a consequence	cushot a	round	to we	aes	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
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_		/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of	delivery
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	s th	ρ	Part II. Other significant condition	ns contributing to death bu	ut not resulting	in the underlying cause giv	en in Part I.			e to the cause of death? Probably 4 Unknown
Vital Records,	The law require rate hes been sig page 2 should b	Completed						24a. Was a autops perform	y prior med? death	
<u>Ia</u>	- G - C	0	25. Was case referred to medica		7		26. Place of Dea	th Check on on		′es 2□ No
	Physicien: this certific at director,	To B	examiner? 1∰ Yes 2☐ No	Hospital: 1 ☐ Inpatie	nt 2 ER/O	utpatient 3 DOA Oth	er: 4 🗆 Nursing H	ome 5 ☐ Reside	ence 6 X Other (S	Specify) SCENE
Division of	ing l	lon:	27. Manner of Death 1 □Natural 5 □ Pendir		Year)	Time of Injury 28c. Injur			ed Shot.	NORR
/ISIC	Attendi	flcat	2 Accident investi	not be 28e. Place of Inju	iry - At home, f	arm, street, factory, office	Yes 2. No			Rural Route Number,
á	s after ai Dire	Certification:	4 Homicide	building, etc	. (Specify)	il		Arnold, K	1 D Amy A	Rural Route Nymber. Citchel HWS
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: / completely filled in by the fi	edical	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the best of Examiner: On the basis of and manner sta	examination at	e, death occurred at the tin nd/or investigation, in my o	ne, date and place pinion, death occu	and due to the ca	ause(s) and manner	as stated
	To t To t	ž	29b. Signature and title of certifie	11 1/2		29c. Licens			9d. Date signed (Me	
	/		30. Name and address of person		aath (Item 23a)	(Type, Print)	CENTER		AUGUST 12	
	2		5.16. 1+1	OGAN 32 Banking	ria Cianat		STREET,	RALTIMOR.	E, MARYLA	ND, 21201
	Sta Registr		31. Date filed (Month, Day, Year) AUG	2 2 2005 Security	r's Signature	Apole				

McKinley Hicks 05-05266 dl

	dΤ		_ For	State of Ma	aryland /	-				and M	ental Hygi	ene			
		1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death										g. No. 2	005	27	380
R	Physicia	an	Decedent's Name (First, Middle, Last)	,							2. Date of Death Month	Day	Year	3. Time of	Death
13	/Medic	al	McKinley Hicks 4a. Facility Name (If not institution, give s	troot and sumbas)			4b. City, T	O1450 O1	1 ocation o	of Death	August		005 unty of Death	9:48	_P
	Examin	er	1901 W. Lafayette				Balt	_		n Death		40.00	only or boun		
	Funeral		5. Social Security Number 11nk 6. Sex	7. Ag	ge (In yrs. last	birthday)	If Under 1		If Under	24 Hrs. Min.	8. Oate of Birth (Month, Day,	Year)	9. Birthp	lace (State o	or Foreign
*	Director		1 🔯	M 2□F	88	Yrs.	Months	Days	Hours		Dec 3, 1			ginia_	
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation						1	0d. Inside C	ity Limits
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	r 28a	rec	10e. Street and Number				10f. Zip (Code			10	g. Citizer	of What Cour	ntry?	
	th witi	ai D	1901 W. Lafayette	e Street					212	23			USA		
	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Exeminer must be notified at	Funeral Director	11. Wantai Status	Armed Forces? If Ye 1 □ Never Married 2 □ Married 1 □ Yes 2 1 ☑ No							cify Yes or No- Rican, etc.)		Race - Americ Black, White,		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes. 2 ☑ No tt Yes, Give Year or Dates:									Sp	pecify: b1	ack	
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and	ntal H ed ot	Ве									e Pascha		mamey		
Maryland 21215-0036	2 should be and Mental is marked a	ည	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F										own, State, Zip	Code)	
	1 and 2 s Health ar tem 27 is		Benjamin Hendrick/half brother 5631 Carisbrook Land								ortsmith	, VA	23703		
ore,	es 1 a of Hei f item r othe	9 E C 20h Place of Disposition 20h Place of Disposition							e)	С	ate 2	Oc. Locat	tion - City or To	own, State	
Ë	Pag ment ant: f ury o	1	4 ☐ Donation 5 ☑ Other (Specify)	in stât	- 1			1-1-							
Baltimore,	permit. Pages 1 Department of H Important: if ite any injury or ot once.		21 Signatur of Funeral Service Licensee Ronal S. Wade Director State Anatomy Board 655 W Baltimore, MD 21201												
****			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that cause ne cause on each I	d the death. [Do not ent	er the mode	of dying	g, such as	cardiac c	r respiratory arre	st,		Approxima Interval Be Onset and	tween
	Physician		Immediate Cause (Final disease or condition	huger	thomis	a (0	molica	ting	other	scle	ctic Codio	CSCu	les disses		Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Numer thornica complicative of the force Codiovascular disease or condition resulting in death) a. Due to or as a consequence of):												
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
	cuted id ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	s											
o,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	s a consequen	ice of):									
8760,	cate be executed physician and the burial-transit	dicai	•	d	-										
9	death certifics e attending pl id for use as t	Physician/Med	IF FEMALE:	3c. If yes, outcome	e of pregnancy	,						230	d. Oate of delive	arv	
Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 4□Pregnant a	2 Fetal de	ath 3[⊒Ectopic pre ∃ Other (spe						Month	,	Year
O.	at the de by the	hysi	9 Unknown	9□ Unknown											
s, p	es tha	by P	Part II. Other significant conditions con	ntributing to death l	but not resultin	ng in the u	nderlying ca	ause give	n in Part I				contribute to t	٤	death? Unknown
ord	w requir been si should	Completed		-								s 2 🗆 N			
3ec	e law has b	mple					· · · · · · · · · · · · · · · · · · ·				24a. Was ar autops perforn	hed?	24b. Were auto prior to co death?	mpletion of	available cause of
le	<i>a □</i>	e Co	25. Was case referred to medical						26 Place	o of Dooth	1 ☐ Yes 2	No	1 🗆 Yes	2 No	
of Vital Records,	Physician: this certific ral director,	To Be	avaminer?	Hospital:	ient 2□ER	VOutpatie	nt 3 DO	A Othe	>C		me 5 ☐ Reside		Other (Special	y) scer	20
			27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inj (Month, D	ay Year) 28	Bb. Time o	Facus 21	8c. Injury Work	at		28d. Describe ho	w injury o	ccurred	o	
sion	death. ctor: Af y the fur	catic	2 Accident investigation 3 Suicide 6 Could not be	8-4-0	\mathcal{C}	31:3	S _M	1 🗆 `			Christ Christ	me	atth	eat	
Division	i or Attene after deatl Director:	Certification:	4 Homicide determined	28e. Place of In building, e	njury - At home atc. <i>(Specify)</i>	e, farm, st	1-				28f. Location (Str	State)		A Poute Nur	nber,
	Hospital or Attending 4 hours after death. Funeral Director: After tely filled in by the fune		29a. Certifier 1. Sertifying Phy	sician: To the bes	t of my knowle	edge, deal	h occurred a		ne, date ar	nd place.	and due to the ca	use(s) an	nd manner as s	tated.	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only one) 2 Medical Exami		of examination										s)
	To the I within 2 To the Complet	ž	29b. Signature and title of certifier	-		20.	29c	License	number		25	d. Date s	signed (Month,	Day, Year)	
			Marill	Lonice	-104	Uh		CME			Aı	ıgust	5, 20	05	
			30. Maine and address of person who to	A . 114	death (Item 23	1 .		Donn	Ctro	20±	Baltimo	60 M	farmi on	4 2 1 20	17
-7.	St	ate	31. Date filed (Month, Day, Year)	32 Regis	trar's Signature		TII.	reilli	DULE	ec,	חמדרדוווס	-e, 1.	атутан	<u>. 4.140</u>	<u>' </u>
	Reaist		AUG 2 2 200	15	es to	60	SALL!								

		-	For State		State of M	Maryland		artment of H		fiental Hyg	jiene		
			Registrar	Name (First, Middle, Las	et)		Cei	tificate of l	Jean	2. Date of Dea	th C	05	G. Time of Death
	Physicia /Medic		1. 5000001113	JOSEPH			НА	MBURGER		AUGUST			2:15 A M
	Examin		4a. Facility Na	me (If not institution, give		er)		4b. City, Town, or	Location of Death	MTILC	4c. Count	ty of Death	BALTIMORE
	Francisco I		5. Social Secu	1 KENMON rity Number 6. S		Age (In yrs. I	ast birthday)	If Under 1 Year	OWINGS If Under 24 Hrs.)	9. Birth	place (State or Foreign
	Funeral Director		212-		X M 2□ F	89		Months Days	Hours Min.	8. Date of Birth Month, Day APR. 29,	1916	NETF	TERLANDS
	ow I	1	10a. State	10b. County	<u> </u>	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary	tor	MD	BAL	TIMORE		OWIN	GS MILLS					1 ☐ Yes 2 🕅 No
	ath with the Marylan 23e or 28e-f show ust be rediffed at	Director	10e. Street an					10f. Zip Code			10g. Citizen of		-
	ath w	rai		1 KENMON					21117	7 7 7		HERL/	
36	72 hours after death with the Maryland naturel; or teme 23e or 28e-f show alcal Examirser must be motified at	y Funerai		itus Married 2 ∑ Married ved 4 □ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	s? X∏No	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🎇 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecry Yes or No- Rican, etc.)	Spec	ack, White	ican Indian, , etc. WHITE
5-0036	"neturel",	Completed by		15. Decedent's Ed	lucation		16a. Dece	dent's Usual Occup	ation		16b. Kind of	Business/Ir	ndustry
215	thin 7.	ple		(Specify only highest gra	College (1-4	or 5+)		kind of work done o	during most of work	ang	METALO		
2121	illed withir I Hygiene. Other than Jent, IDS M.	Con			4		EXEC	UTIVE	40.14.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.	(F) . A () ()	METALS		
Maryland	ges 1 and 2 should be filed within 72 hc to f Health and Mental Hygiene. If Item 27 is marked other than "natur or other treumatic event, Ins Madical	Be		ame (First, Middle, Last)			HAMD	LIDCED	18. Mother's Nam	e (First, Middle,	Maiden Suma		NOBTAINABLE
<u> </u>	2 should be and Mental is marked of reumatic ev	ဥ	SOLOI	YUN it's Name/Relationship (Type Print)			URGER		al Route Numbe	r. City or Tow		
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ē,	is 1 and of Health Item 27 other tr		20a. Method o	f Disposition		20b. P	lace of Dispo	sition (Name of matory or other place		Date	20c. Location		
Ë	Pages nent of nt: If I			I 2 □ Cremation 3 □ tion 5 □ Other (Specif		110	-	OH CEMETE	· I	9/2005	WOODLA	WN, N	MD
Baltimore,	permit. Pages Department of Importent: If II any njury or ones.		21. Signature	Funeral Service Licer	Cettle		22	2. Name and Address	ss of Facility SO	L LEVINS	SON & E	ROS.	, INC.
П			23a. Part1. E	nter the disease, or com r heart failure. List only	plications that cau	sed the death	. Do not en	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician	6 0	Immediate Ca	ause (Final Indition	· hos	out	Jail.	uso					Onset and Death
	/Medical Examiner		resulting in de	eath)	Due to (or	as a consequ	erce of):	,				1	
		Examiner	Cause (Disea	ist conditions, to immediate Underlying se or injury	b. Due to (or	as a cons	uence of):	try	disea	se.			25 year
68760,	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	edicai Exal	that initiated e resulting in de	eath) Last	Due to (or	as a consequ	uence of):						
	eath certificate lattending physifor use as the h	/Medi	IF FEMALE:	cedent pregnant	23c. If yes, outco	me of pregna	incy				23d. D	ate of deliv	very
.O. Box	that the death ad by the atter detached for u	Completed by Physician/M	in the pa	st 12 months? 2 □ No		n 2 □ Fetal tat time of de n		Ectopic pregnancy Other (specify)			N	fonth	Day Year
Division of Vital Records, P	uires that signed b	d by Pł	Part II. Other	significant conditions of	contributing to deat	th but not resi	ulting in the u	inderlying cause giv	en in Part I.		obacco use co ′es 2□No		the cause of death?
O	s been si	ojete	met	ral valve	resi	lace.	nex	<i>†</i> .		24a. Was		. Were aut	topsy findings available ompletion of cause of
Re	: The lav cate has page 2	Шо	atria	1 lila	Vation					autop perfor	med?	death?	2 No
ita	certifica rector, p	BeC	25. Was case examiner	referr to medical	(acco)	`			26. Place of Dea		/		
<u>></u>	d is	2	1 🗆 Yes	2X No		atient 2			4 Nutsing Fi	ome 5 Resid			ify)
n c	ding Ph After th funeral	ùo:	27. Manner of	al 5 Pending	28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time of Injury	Wor		28d. stribe h	ow injury occi	urred	
Sio	Attendi death. ctor: A y the fu	Certification;	Z ☐ Accid	de 6 Could not b	e Goo Blace of	Injury - At ho	nme farm st	M 1 [Yes 2 □No	28f. Location (S	treet and Nun	nber or Rui	ral Route Number,
Σ	7 8 7 6	ertif	4 🗌 Hom	icide determined	building	, etc. (Specif	y)	iout, lautory, uniou		City or Tow			
_	Hospitel 4 hours Funerel tely filled	Medical Co	29a. Certifier (Check o	1 Certifying Ph	niner: On the basi	is of examina	wiedge, deat tion and/or in	h occurred at the tire	ne, date and place, pinion, death occur	and due to the orred at the time, or	cause(s) and r	nanner as e, and due	stated. to the cause(s)
	To the within 2 To the complet	Med		e and title of certifier	and manner	siated.		29c. Licens	e number		29d. Date sign	ned (Month	n, Day, Year)
}	£ ₹ ₹ 8			hanse V	Atr	aka	1)		0249	1	_	,	12005
Ì	0		30. Name and	address of person who	-	of death (Iten	_	Print)	RD-	,	340		21093
	Sta	ate		(Month, Day, Year)	32. F#9	jistrar's Signa		lake					
	Regist			AUG 2 2	2005	EUR.	15 B						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 8 per FH, G852, 026246 Och Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** August 9, 2005 9:15 AM M Erika E. Heyn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 305 E. Joppa Road #1808 Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dev. Yeer) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1 ■ M 2 F 79 468-42-3873 Germany Director March 16,1926 Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2√ No Directo MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 E. Joppa Road #1808 or Items 23a 21286 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: Specify: White 3 ☐ Widowed 4 ☼ Divorced Year or Dates: "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) chef 12 cruise ships 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Zoller 2 Erwin Heyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobbie Millner/friend 2230 Springlake Drive Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: If Ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4
 Donation 5
 Other (Specify) 21. Sign turs of Euneral Struce Licensee Ronal Wade, Di State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 7000/ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, pe 2 🗆 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 ☐ Yes 2 director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 2 Hospital: 2 ER/Outpatient မှ 1 🗌 Yes 1 Inpatient 3□ DOA sidence 6 Other (Specify) 5 the funeral 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 Pending investigation death. 1 Tyes 2 □ No within 24 hours after deat To the Funeral Director: completely tilled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifies and manner stated. 29b. Sig 30 use of death (Item 23a) (Type, Print)

State Registrar 32. Reg

0 2005

AUG 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gloria Holthaus 1- State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death 05-05140 Reg. No. NJM 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month Year Gloria Holthaus /Medical July 3Ó 2005 2010 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3217 White Avenue Baltimore Baltimore City 5. Social Security Number Under 1 Year If Under 24 Hrs. 8. Date of Birth onths Days Hours Min. July 13, 1964 Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
unk Months 1 □ M 2 🖺 F 41 Director Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28e-f ahow r than "natural", or Items 23a or 28e-f ahov tre Medical Examiner must be notified at 10d. Inside City Limits Director MD 1√ Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 660 Elsrode Avenue Funerai 21239 unk Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 þ Specify: White 1 ☐ Yes 2K No 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Il Hygiene. other then College (1-4or 5+) unk unk unk unk 17. Father's Name (First, Middle, Last) Be unk 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Itam 27 I other tra O.C.M.E. 111 Penn Street Baltimore, MD 21201 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ō 20c. Location - City or Town, State = 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State Depertment of Important: If any injury or once. 4 □Donation 5 ☑ Other (Specify)in state 21. Signature of Funeral Service Licensee Ronald S, Wage 22 Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street nun Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Narcotic, Cocaine, and Tramadol Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): death certificate be executed burial-tran and Due to (or as a consequence of): physicien Physician/Medicai the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery ō 3 DEctopic pregnancy 4 Pregnant at time of death Month Day Year o the detached 5 Other (specify) 9 Unknown Unknown signed by ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, à 23e. Did tobacco use contribute to the cause of death? Completed 2 No 1 Yes 3 Probably 4 Unknown page 2 has 24b. Were autopsy lindings available prior to completion of cause of death?

1 se 2 No 24a. Was an Yes 2 No 25. Was case reterred to medical director Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ၉ Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \mathbf{X} Other (Specify) this Scene 27. Manner of Death 28a. Date of Injury Formorth, Day 7-30-05 Certification: 28b. Time of After 28c. Injury at Work? or Attending 28d. Describe how injury occurred 1 Natural 5 Pending Year) unk efter death. I Director: Ali d in by the fur F8:00 2 Accident investigation 1 ☐ Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - Al home, larm, street, lactory, office building, etc. (Specify) filled in by Location (Street and Number of Rural Route Number, City or Town, State) 3217 White Ave. 4 Homicide To the Hospital within 24 hours e To the Funeral C House Baltimore, Md 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of certifier

State Registrar

AUG 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Morte

AMPA

31. Date filed (Month, Day, Year)

14 URGLL Penn St., Baltimore, MD 21201 32. Registrar's Signature

29c. License number

OCME

29d. Date signed (Month, Day, Year)

July, 31, 2005

			1 - For State Registrar	State o	Maryland / Department	artment of H		id Mental Hy	giene Reg. No.	n n5	27381
	Physici	an	1. Decedent's Name (First, Middle	, Last)				2. Date of De	ath Day	Year	3. Time of Death
	/Medic	al	Richard Lee Jo			T.,		August	14.	2005	9:51 A M
	Examin	er	4a. Facility Name (If not institution, 720 Water's Ed		nber)	4b. City, Town, or		Death	- 1	County of Dea	th
Н	Funeral		5. Social Security Number		7. Age (In yrs. last birthday)	Sykesvi.	If Under 24	Hrs. 8. Date of Bir	th	arro11	thplace (State or Foreign
	Director		061-20-4794	1 ∑ M 2□F	78 Yrs.	Months Days	Hours	Min. (Month, Da		_ C	ountry) V York
	w w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Maryli f sho	o		1							1 ☐ Yes 2 ☑ No
	r 28a-	Director	MD Carrol 10e. Street and Number	<u>. L</u>	Sykesvil.	10f. Zip Code			10g. Citiz	zen of What Co	ountry?
	th witt		720 Water's Edg	ge Court		21784			Unit	ed Stat	es
	ams ams	Funeral	11. Marital Status	Armed Fo	dent Ever in U.S. 13.	Was Decedent of Hi	spanic Origin n, Mexican, F	? (Specify Yes or No uerto Rican, etc.)		4. Race - Ame Black, Whit	erican Indian,
36	hours after death with the Maryland tural, or itams 23a or 28s-1 show at Exarcities frights be nulliked at	by Fu	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ∑Yes If Yes, Giv Year or Da	2 No	1 ☐ Yes 2 🎇 No	Specify:			Specify:	
21215-0036	"natural",		15. Decedent	's Education	16a. Dece	dent's Usual Occupa	ation		16b. Kir	What of Business	lite
215	d within 72 jiene. r than "nat	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1	life.	kind of work done a DO NOT use retired,	luring most oi)	f working			
2	e filed withir Il Hygiene. other than vant, tre M	Con		9		ıary				urance	
and	d to be	Be	17. Father's Name (First, Middle, I					Name (First, Middle,	, Maiden S	Sumame)	
Maryland	2 should be and Mental is marked (2	Lorenzo Frank J 19a. Informant's Name/Relationsh		19h Maili	ng Address (Street a	I1ah	Lee or Rural Route Numb	er City or	Town State	Zin Code)
	D = 7. =		Angelina Johe	Wife	1			ırt Sykes			21784
e,	of Heal		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place	9)	Date		cation - City or	
Ë	Pages ment of I ant: If Its ury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Lake View		' A11	gust 18, 2005	Sykon	sville,	MO
Baltimore,	permit. Pages Department of Important: If I any Injury or once.		21. Sign sture of Funeral Service	jcense		2. Name and Addres				- 33	
	70 7 8 0		22 Part Fator the disease or	Cavi	used the death. Denot as	212 W. 016	Libe	neral Home rty Road	Winf	ield, M	
H			27a. Part1 Enter the disease, or shook, or heart failure. List	only one cause on e	ach line.	,	1		rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Due to (ongestive	heart	fee	lure			years.
	Examiner				or as apprisoquence or,.		0				
	ב פ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (טן מש פטוזששעשהונט טוֹ).						
V	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. — Due to /							
8760,	cate be executed obysician and the burial-transit		,	Due 10 (or as a consequence of):						
687	fficate g phys as the	hysician/Medical		d		-					
Вох	death certific: e attending pt id for use as t	In/M	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy	Testania arangana			2	3d. Date of del	ivery
	ne deat the attr	sicia	in the past 12 months? 1 Yes 2 No		ant at time of death 5	Ectopic pregnancy Other (specify)				Month	Day Year
P.0	by ac	Phy	9 Unknown				- 1- 8 1	og - Dida			
ds,	es be	d by	Part II. Other significant conditio	ns contributing to de	atti but not resulting in the u	ndenying cause give	in in Part I.		obacco us Yes 2□		the cause of death? obably 4 Unknown
COL	v requ	iete						24a. Was			itopsy findings available
Vital Record	e la has je 2	ompieted						— autor	rmed?	prior to death?	completion of cause of
ita	i cia n: Th certificate rector, pag	e C	25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check only of	254No	1 🗆 Yes	2 No
of V		To B	examiner?	Hospital: 1 🗆 I	npatient 2 ER/Outpatier	nt 3 DOA Othe	r: 4 🗆 Nursi	ng Home 5 Nesid	dence 6	Other (Spec	cify)
	ing P	ion:	27. Manner of Death 1 Matural 5 □ Pending	9	of Injury h, Day Year) 28b. Time o Injury	Work	?	28d. Describe l	now injury	occurred	
Division	or Attanding after death. Diractor: After in by the fune	ertification;	2 Accident investig 3 Suicide 6 Could n	ot be	of Injury - At home, farm, sti		fes 2□No	28f Location (Street and	Number or B	ıral Route Number,
Σ	after Dirac	ertii	4 Homicide determi	ned buildir	ig, etc. (Specify)	eet, factory, office		City or Tox	vn, State)	THE THE STATE OF THE	rai riodio Nuiriber,
	Hospital	dical C	29a. Certifier 1 Certifying (Check only 2 Medical E	g Physician: To the	best of my knowledge, deat	h occurred at the tim	e, date and p	lace, and due to the	cause(s) a	and manner as	stated.
	To the Hospital or Attanding Physwithin 24 hours after death. To tha Funeral Director: After this completely filled in by the funeral directors.	w w	Uney	and manr	sis of examination and/or in er stated.	vestigation, in my op	inion, death o	occurred at the time,	date and	place, and due	to the cause(s)
	To the within 2 To tha complet	Σ	29b. Signature and title of certifier	J. MD		29c. License	number	,	1	signed (Monti	
	1	U	20 Alema and addition		William Tou		7077	/	2000	15+ 1	0,2005
	15	11	30. Name and address of person v	who completed caus L Road	e of death (Item 23a) (Type,		21	784	ैं		
	Sta	te	31. Date filed (Month, Day, Year)		Bistrar's Signature	P 10 .		, , ,			
•	Registr	ar	AUG 2 2	2005	seven D. My	pere					

		•	1 - For Amend Item 201 Registrar	State of Maryla per fh G846	nd / Depa 8-22-(irtment of H	ealth and Death	Mental Hy	giene Reg. Nø?	15 2738	5
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Dea	.th
	/Media	al	OLIVIA J 4a. Facility Name (If not institution, give s	ONES		4b. City, Town, or	Location of Dog	AUG	19 2 4c. County	2005 10:101	₹ M
à,	Examin	er	UNIVERSITY OF MARYLAN		TER	-	TIMORI		N	/A	
	Funeral Director		415-74-1116	M 2 A F	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir (Month, Da	th (6, 1929	9. Birthplace (State or Fo County) Wishin gton,	reign
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County N/A		ity, Town or Lo					10d. Inside City Li 1 🔀 Yes 2	
	th with the 23s or 28e	Funeral Director	10e. Street and Number 417 Lynd hurs	t Street		10f. Zip Code 2/2	29		10g, Citizen of V Unite	vhat Country? d States	
036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-1 show Ite Modeal Exemitier cast De notified at	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 M No IJ Yes, Give Year or Dates:	'	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 1 No	ispanic Origin? (\$ n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Blac	e - American Indian, ck, White, etc. r: Black	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-1 show or other traumatic event. It is Marical Examinatic and be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occupi kind of work done of DO NOT use retired burer	during most of wo	orking		siness/Industry	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Itte Ma	To Be C	17. Father's Name (First, Middle, Last) I SUAC Simms				Mari	me (First, Middle e Gold	sberry		
	1 and 2 shored Health and N tem 27 Is master		19a Informant's Name/Relationship (Ty, Kevin W. Jones	-Son	19b. Mailin 417 L Place of Dispo					State, Zip Code) Ary (and 212	29
Baltimore,	Pa mer ury		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Ar	butus /	natory or other place Nemorial F	ark Aug		Boutin	city or Town, State core, Maryla,	nd
Bal	permit. Departr Importe any loja		21. Signature of Funeral Service License	O Dan		Name and Address	10,111 kms	1 hmore	Mary (nd 21229	
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the decide cause on each line.	ath. Do not ent		g, such as cardia			Approximate Interval Between Onset and Deat	h
	/Medical Examiner			Due to (or as a conse	equence of):					11	
	pe is	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter the period Cause (Disease or injury	Due to (or as a conse	equence of):						
8760,	icate be executed physician and s the burial-transit	dlcal Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
.O. Box 68	ne death certif the attending thed for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregi 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	e ol delivery nth Day Year	
<u>α</u>	es be	by	Part II. Other significant conditions cor	stributing to death but not re	esulting in the u	nderlying cause give	en in Part I.			nbute to the cause of death	
I Records,	The law ate has b page 2 st	Completed						24a. Was autor perfo 1 Yes	osy pormed? c	Nere autopsy findings avail prior to completion of cause feath? Yes 2 No	able of
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	lospital:		oth	er	ath (Check only o			
o	ng ifter Innel	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Magnetient 2 (28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	4 □ Nursing i	Home 5 ☐ Resident 28d. Describe	dence 6 Other		
Division	ne Hospital or Attendi n 24 hours after death. ne Funeral Director: A pletely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	set, factory, office		28f. Location (: City or Tou		er or Rural Route Number,	
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical (29a. Certifier 1 Certifying Physical Control (Check only one)	sician: To the best of my kr ner: On the basis of examinand manner stated.	nowledge, death nation and/or in	occurred at the tin restigation, in my of	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	A		29c. License	e number		29d. Date signed	(Month, Day, Year)	
)	5		1. Now	uller, n	10	P	17670	S	Aug	19.2005	
L	{		30. Name and address of person who co		em 23a) (Туре, ИО б		teene	Balti	MOSE,V	mo 2120	1
2	Sta Regist		31. Date liled (Month, Day, Year)	32. Registrar's Sign	nature	Cook					

Amend item#8, perfrh, C846, 8/23/05 III State of Maryland / Department of Health and Mental Hygiene

			For State	State of Maryla		artment of H <i>rtificate of l</i>			000-	
			Registrar 1. Decedent's Name (First, Middle,	Last)	061	tincate or t	Jean	Reg. 2. Date of Death	No. Z	3: Time of Death
	Physici /Medic		JANIE J	OHNSON				Month	Day Year	19:03 M
	Examin		4a. Facility Name (If not institution,				Location of Death		4c. County of Dea	th
				US BAY VIEW	a da ad birdhida	If Under 1 Year	If Under 24 Hrs.	10 Date of Birth	N/A	
	Funeral Director		5. Social Security Number 2/2-28-0343 Usual Residence of Decedent	3. Sex 7. Age (In yr	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Mar. 9,	1924 VII	thplace (State or Foreign ountry) GINA
	aryland	7	10a. State 10b. County		Baltir					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28a-f	Funeral Director	Maryland Bal 100. Street and Number 127 Chest n		1761111	10f. Zip Code		10g	Cifizen of What C	•
	s 23a	ral				2/2			Lnited	STARS
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importants: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, it a Medical Establish in any injury or other traumatic event, it a Medical Establish in any injury or other traumatic event.	by	11. Marital Slatus 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? d 1 Yes 2 No If Yes, Give Year or Dates:	•	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
5	n 72 h	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turina most of work	ing	o. Kind of Business	2
212	filed within Hygiene Ither than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		am stress	,	10	arker Mi	g. Co.
	uld be filed fental Hyg rked othe lic event,	To Be C	17. Father's Name (First, Middle, La	ast)			18. Mother's Nam Hatt	e (First, Middle, Mai	den Sumame)	
Maryland	1 and 2 should Health and Men Iom 27 Is marke other traumatic		19a. Informant's Nama/Relationshi	p (Type, Print) XL		Address (Street a		BUITME	ity or Town, State,	Zip Code) And 2/223
Baltimore,	Peges 1 a nent of He: int: If item iry or othe		20a. Method of Disposition 1 □ Burial 2 Ocremation 3 1 □ Donation 5 □ Other (Spe	Bemoval from State	Place of Dispo	sition (Name of patory or other place	· Aug	Date 2 2 200	Baltmer	Town, Sfate
Balti	permit. Pege Department Important: If any injury or once.		21. Signature of Funeral Service Li				ss of Fagility 1/1 c	ns Juner		
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused the de					, ,,,,,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	GASTRO-	INTESTI	NAL BLE	EED			Onset and Death
- 20.	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):	1.0				DATS
		er	Sequentially list conditions, if any, leading to immediate	b. ANT CO A o		IOIV				D4 /3
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· DEEP	VEN	lous Ti	HEDNBO	515		DAYS
60,	ificate be executed physicien and as the burial-transit	E	resulting in death) Last	Due to (or as a cons	equence of);					
68760,	physicate I	edical		d						
Вох	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ❷No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Dafe of de Month	livery Day Year
P.0.	that the ed by detac	/ Ph	Part II. Other significant condition	s contributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	w requires to been signed should be	ed by		RY FIBROSIS				1 ☐ Yes	2 (\$No 3 P	robably 4 DUnknown
Reco	he law re s has bei ge 2 sho	Completed						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
ta	ilcien: The lav certificate has rector, page 2	0	25. Was case referred to medical				26 Place of Deat	1 ☐ Yes 2 ☐		2 □ No
<u> </u>	ysici	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Mnpatient 2	☐ ER/Outpatien	it 3□ DOA Othe	10	ome 5 Residenc	e 6 Other (Spe	icify)
o uo	Attending Physician: or death. ector: After this certification in the funeral director.		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investiga		28b. Time of Injury	Work	vat (? Yes 2 □ No	28d. Describe how	injury occurred	
Division of Vital Records,	after des after des Director	Certification:	3 Suicide 6 Could no 4 Homicide determin		home, farm, str cify)	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
_	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my k xaminer: On the basis of exami	nowledge, death	n occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the caus	e(s) and manner as and place, and due	s stated.
)	To the within To the comple	Med	29b. Signature and title of certifier	and manner stated. AB ND N		29c. License	number	29d.	Date signed (Mon	h, Day, Year)
١	0		30. Name and address of person w	the completed squae of death /le	om 23a) /Tuga	PrinI)	33709		0 11	2005
3	Sta	te	31. Date filed (Month, Day, Year)	KH 4940 L 32. Registrar's Sig	nature TE	RN AV	ENUE	DATETIME	RE MI	12124
	Registr	4.	AUG 2	32. Registrar's Sig	Mr by	polis				

Joseph Jacobs 05-5218 AKG

Amend Please Type or Print in Black/Indelible Ink. Ensure All Copies Are Legible.

		Registrar	tem 23 4 27 92		Cei	rtificate	e of	Death			Reg. No.	200	5 2720
Physic	ian	1. Decedent's Name (First, Mid	, ===,							2. Date of De Month	Day	Yea	3. Time of Deat
/Med Exami		Joseph Jacobs 4a. Facility Name (If not institut		ar)		4h Cihi	Tours	. Loopting	-4 D11	Augus	t 2,	2005	4:33 P
LAGIIII		Saint Joseph				Tows		Location	or Death			County of De	
Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. la	st birthday)	If Under	1 Year	If Under		8. Date of Bir	th	9. 6	ore County
Director		unk Usual Residence of Decedent	1 ⊠ M 2□F	49	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Dec 10	195	5 ι	Birthplace (State or Fore Country) 1nk
yland		10a. State 10b. Cour	nty	10c. City,	Town or Lo	cation							10d. Inside City Lim
the Marylar 28a-f show	Director	MD Balt	imore	Tow	son								1 □ Yes 2 🔯
or 28	Dire	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What	Country?
• 23a	rai	509 E. Joppa					212				u	ınk	
iteme:	Funeral	11. Marital Status unk 1 □ Never Married 2 □ M	12. Was Deceder Armed Forces	<u>s</u> ?	. 13. \	Vas Deced f Yes, spec	ent of Hi rfy Cuba	spanic Ori n, Mexican	gin? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	- 14		nerican Indian,
within 72 hours after deeth with the Maryland ene. than "naturat" or iteme 23e or 28e-f show na Mudical Evantirat must be notified at	þ	3 ☐ Widowed 4 ☐ Divorc	If Voc Civo			☐ Yes 2	No 🖺	Specify:			S	-	lack
72 hours "natural", dical Exp	Completed	15. Deced	ent's Education nest grade completed)		16a. Deced	lent's Usual	Occupa	ation			16b. Kind	d of Busines	ss/Industry
be filed within 72 hotal Hygiene. Ind Other then "nature event, the Medice.	de la	Elementary/Secondary (0-12		r 5+)	life. L	kind of work OO NOT us	k done a e retired	luring mosi)	t of work	ing		0. 20000	, a mad stry
e filed within Hygiene. other then		unk	unk			unk						unk	
od of	Be	17. Father's Name (First, Middle	e, Last) unk					18. Mothe	r's Name	e (First, Middle,	Maiden S	umame)	unk
s 1 and 2 should by if Health and Menta Item 27 is marked other traumatic events.	10	19a. Informant's Name/Relatio	nshin (Tyne Print)		10h Mailie	- 4 4 4	/0:						
nd 2 salth ar 27 is r trau		O.C.M.E.	11,000,771111,7							al Route Number			, Zip Code)
es 1 and 2 of Health of Item 27 i		20a. Method of Disposition		20b. Pla	ce of Dispos	sition (Name	e of	-		ore, MD			or Town, State
		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🗷 Other	n 3□Removalfrom State (Specify)in state	e cer	netery, crem	atory or oth	her place	e)					, Town, State
permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service Ronal d	C II-/ // D/	ector	S1 Ba	Name and tate A	Addres Anat	s of Facility Omy B	oard 1201	l 655 W.	Bal	timore	Street
		23a. Part1. Enter the disease shock, of heart failure. Li	or complications that cause st only one cause on each	ed the death.	Do not ente	r the mode	of dying	, such as	cardiac c	or respiratory ar	rest,		Approximate
Physician		Immediate Cause (Final disease or condition	Complic		of ne	eck in	niur	V					Interval Between Onset and Death
/Medical Examiner		resulting in death)		s a conseque			-5						
	125	Sequentially list conditions,	b										
nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a conseque	nce of):								
execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as	s a conseque	nce of):								
ficate be executed physician and s the burial-transit	dicai		d										
⇒ 0, a	Medi	IS SENALS											
that the death certifi ed by the ettending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pred	2222				230	d. Date of de	elivery
0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant a			Other (spec						Month	Day Year
hat th od by detach	Ph												
es De	33	Part II. Other significant condit	nons commoding to death i	but not resulti	ng in the uni	deriying cau	ise giver	n in Part I.			1.6		to the cause of death?
w requir been s should	ete								_	1 U Y	es 2 12/1	No 3 □ P	robably 4 Dunknow
The lay	Completed									24a. Was a autops	sy	prior to	utopsy findings available completion of cause of
ysician: The t is certificete ha director, page	a)	25. Was case referred to medic	al								2□No	death?	s 2□ No
Physician: this certifice ral director, p	To B	examiner? 1 ⊈Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 VE	VOutpatient	2 DO 4				(Check only on			
E = E		27. Manner of Death	28a. Date of Inju	ury 2	Bb. Time of	280	. Injury a Work?	4 14013		ne 5 ☐ Reside 8d. Describe ho			
endir sath. or: Af he fur	atlo		igation August 2	2005		2:58	Work?	es 2 N			, ,		unk
or Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	not be nined 28e. Place of In building, et			et, factory, o	office		Fr	8f. Location (St	reet and N	lumber or R	ural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifyi (Check only 2 Madica	ng Physician: To the best Examinar: On the basis of and manner st	of my knowle	edge, death	occurred at	the time	, date and		towson,	rid B	altimor	e, MD
To the within 2 To the complet		one) 29b. Signature and title of certific		ated.					. 0000178				
⊢ 3 ⊢ 8		In A Akan	HALL OCA				icense i						h. Day, Year)
	-	30. Name and address of person	who completed cause of	death /ltc= 31	20) /T C).C.	M.E.		Au	igust	3, 20	JU5
		Yamela B. E	withail, mi		111		ı St	reet,	Ba1	timore,	Mary]	land	21201
Sta	(e	31. Date filed (Month, Day, Year	32. Registr	ar's Signature									

			1 - For State Registrar	State of Mar		artment of H		lental H	ygien Reg. N	~	nns.	2720
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last)		Kenny	4b. City, Town, or	Location of Death	2. Date of D	ا _ D	ay 17 c. Coun	Year 2-CO5	2:05 AM
The state of the s	Funeral Director	ŕ	Howard County 5. Social Security Number 6. Sex 1 205, 20, 6468 Usual Residence of Decedent		(In yrs. last birthday)			8. Date of E (Month, I		How	ard	ace (State or Foreigr 1, PA
	Maryland B-f show		10a. State 10b. County MD Howard	1	Oc. City, Town or Lo	ocation lumbia	· · · · · · · · · · · · · · · · · · ·			-		d. Inside City Limits
	ath with the 128 or 28	Funeral Director	10e. Street and Number 9501 Wandering			10f. Zip Code 210				itizen of	f What Count USA	ry?
9036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notitled at	d by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	VO-	Bi	ace - America ack, White, e ify : $\mathrm{B1ac}$	tc.
21215-0036	I within liene.	Completed by	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of workii)	ng			Business/Indi	ŕ
Maryland	should be filed ind Mental Hygin is marked other umatic event, II	To Be (17. Father's Name (First, Middle, Last) Llewelyn McNea				18. Mother's Name	e Car	np			
	t and 2 Health a em 27 is		19a. Informant's Name/Relationship (Type Daphne Jackson 20a. Method of Disposition		er 350	4 Green	wood Ter	race.	. Gr	een	n, State, Zip (1 S b o r c	
Baltimore,	permit. Pages Depertment of Important: if it any injury or o		1 Burial 2 Cremation 3 Ri 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		St. Joh		e. 8/22/ s of Facility Witz Knolls					City,Md.
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to (or as a c	to death. Do not enter to death. Do not enter	re the mode of dying	f, such as cardiac o	r respiratory	Colu	ım b		A 21045 Approximate Interval Between Onset and Death, Scionus
,0928	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a complete of the complete of th	onseguence of).	ngitat					10	years years
P.O. Box 6	the death certific y the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 (4 Pregnant at tin 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)					ate of deliver	y Day Year
	w requires that the de been signed by the s should be detached f	þ	Part II. Other significant conditions con	tributing to death but r	not resulting in the u	nderlying cause give	on in Part I.			use cor		cause of death?
Vital Records,		e Completed	25. Was case referred to medical					per 1 ☐ Yes	opsy formed? 2 \(\) No			sy findings available pletion of cause of
Division of Vi	Phys this al di	Certification: To B	eyaminer?	28a. Date of Injury (Month, Day Y	- At home, farm, str	28c. Injury Work M 1 \(\)	at 2 No	ne 5 Res	sidence how inju	nd Num	rred	Route Number,
Ö	Hospite 14 hours Funerel 19ly fille	edical Cert		building, etc. (cian: To the best of recipion of example and manner states	ny knowledge, death	n occurred at the tim restigation, in my op	e, date and place, a inion, death occurre	City or To	2 (21150/5	m bas (s	anner as stat and due to t	ied. he cause(s)
	To the within 2 To the complet	5	29b. Signature and title of certifier ALONGE 1. J			29c. License	number 4JF5		29d. Da	ate signe	ed (Month, Di	1y, Year)
	Sta	te	30. Name and address of person who cor Park Why Sur X 31. Date filed (Month) Day, Year)	npleted cause of deat	th (Item 23a) (Type, Columbi Signature	Print) HPV	Heart, 1	11083	5 4	ittle	Ret	uyent
DH	Registr MH 17 Rev 1/20	al *	AUG 2 2 2	32. Régistrar's	w the p	profes						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Kroner 3:05 PM million 20, 2005 nones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** westminster Morrie HP510131 enter If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Nov 27 9. Birthplace (State or Foreign 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 92 215-07-5266 Md **Director** Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

9m 27 is marked other than *natural', or items 23s or 28s-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, in a Madical Execution or marke notified at Md Mt. Airy Frederick 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13250 Penn Shop Road 21771 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: white If Yes, Give-Year or Dates: 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) press room foreman Gordon Carton Co. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Paul Kroner Nettie Rollins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat QDCE. Bill Kroner, Jr. (son) 13250 Penn Shop Rd., Mt. Airy, Md 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Lake View Memorial 8-25-05 Sykesville, Md 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel endeent Parge Haight P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 300YS **Physician** 2220101 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for sela consequence of Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical ate has been signed by the attending physi page 2 should be detached for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ MYOCARdial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Tes 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA 27. Mary er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 29a Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the To the

State Registrar

29b. Signature and title of certifier

John (. Ansel

31 Date filed (Month.

30. Name and address of person into completed cause of death (Item 23a) (Type, Print)

32. Re

295

2005

, NO

Pay Xear)

trar's Signature

29c. License number

00059943

westminster

29d. Date signed (Month, Day, Year)

20,2005

			For State Registrar	State of Marylan		artment of F rtificate of		-	giene 005	27390
	Physicia	an	1. Decedent's Name (First, Middle, Las	•				2. Date of De. Month	Day Year	3. Time of Death
	/Medic	al .	Donald Glenn Lent			4h City Town	or Location of Death	August	16, 2005 4c. County of Dea	11:40 P M
	Examin	er	Carroll Hospital	·		Westminst			Carroll	ut
	Funeral Director		5. Social Security Number 6. Security Number 214-36-9266			If Under 1 Year Months Days		8. Date of Bird (Month, Da Aug 17	th 9. Bir	thplace (State or Foreign puntry) yland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	a-f sh	ctor	Maryland Carroll	Wo	odbine					1 ☐ Yes 2 🔯 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	
	s 23e		5115 Woodbine Rd.	12. Was Decedent Ever in U	S 13	21797	Hispanic Origin? (Sp	ecify Yes or No	United Sta	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumente event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ♣ No	Hispanic Origin? (Spian, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi Specify: Whi	te, etc.
Maryland 21215-0036	72 ho natur	Completed	15. Decedent's Ed (Specify only highest gra	Jucation de completed)	(Give	dent's Usual Occup	during most of work	ing	16b. Kind of Business	/Industry
121	within 8ne. then	iduic	Elementary/Secondary (0-12) 8th	College (1-4or 5+)	Farme	DO NOT use retire	d)		agricultur	e
1d 2	I Hygid other	Be Co	17. Father's Name (First, Middle, Last)		Turme	<u>-</u>			Maiden Sumame)	
ylar	2 should be t and Mental I is marked o' sumatic eve	To B	Sterling Walter I				Emma Caro			
Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (7) Patricia Ethel Lei			•	Rd. Woodl		er, City or Town, State,	Zip Code)
ds.	s 1 and 2 of Heelth Item 27 i		20a. Method of Disposition	20b. F	-	osition (Name of matory or other pla		Date Tile	20c. Location - City or	Town, State
OE.	Pages nent of int: If I		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Memoval from State		uth Cem.	8/20/2	2005	Smallwood,	MD
Baltimore,	permit. Pages 1 Department of H Important: if Ite any injury or ot once.		21. Signature of Funeral Service Licen	Molen					& Cremator	
	Pnysician	2 0	23a. Part1. Enter the disease, or compensors, or heart failure. List only immediate Cause (Final disease or condition	plications that caused the deat one cause on each line. Bowel Obst					0	Approximate Interval Between Onset and Death Hours
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		<u>ة</u>	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying	b. Carcinoma o		Esophagus	S			6months
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		For State Registrar	State of M	aryland		artment of H		ind Me		giene Reg. No.	0000	07001
Physicia		1. Decedent's Name (First, Middle,	Last)	a the					2. Date of Dea August	ıth 6.	. U U 5 5,200 5 °	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution,	give street and number)	V/C		4b. City, Town, o	r Location of	f Death		4c. (County of Death	120123 1
		Lorien Nursi				Colum					Howard	
Funeral Director		124.10.5089	i. Sex 7. Ag 1 1 1 1 7 1 7 1 Ag	96 (In yrs. Ia 86	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day March 2	r, Year)	9. Birth Cou .919 New	place (State or Foreign ntry) York
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
Many Re-f sh	tor	Md Howa	rd	C	columb	ia						1 ☐ Yes 2 ☐ X lo
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portilliore, Mal yialing 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mentall Hygiene. Important: If tier 27 is marked other than "natural", or items 28c or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 [XYes 2 If Yes, Give Year or Dates:		li li	Vas Decedent of H Yes, specify Cuba □ Yes 2\\\X\\	ispanic Orig in, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- lican, etc.)		4. Race - Americ Black, White, Specify: Whi	etc.
72 hc	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	ent's Usual Occup	ation	of working		16b. Kin	d of Business/In	dustry
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i, widily and 2 shou salth and h n 27 is mail ier trauma		19a. Informant's Name/Relationship Madeline C. Al		ghter	19b. Mailin 9145	g Address (Street a	and Number n Lane	or Rural	Route Number olumbia	r City or Md	Town, State, Zip 21045	Code)
ges 1 tof High or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐ Removal from State	ce	m <i>etery, cr</i> em	sition (Name of natory or other place		Da		20c. Loc	ation - City or To	own, State
t. Pa rtmen rtant: njury		`4 Donation 5 □ Other (Spe	cify)	Ga	rrisor	Forest Cemete	Vet 8	22 2	2005	Owi	ngs Mil	ls, Md
permi Departi Import any ir		21. Signature of Funeral Service L	adema	~	55	Name and Address 555Twin K	nolls	Witz Rd.			Hames Ma Žio	₄₅ Inc.
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	oneque	ence of):	ART	_		DISE		E	Approximate Interval Between Onset and Death
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or with	<	29b. Signature and title of certifier Sfup1	RHD			29c. License	number 2 (021	2	9d. Date	signed (Month, i	Day, Year)
167		30. Name and address of person when Shakunna	o completed cause of d	eath (Item 2	23a) (Type, F	SANTIA	GOR	04	0 50	116	INBIA	2 21045
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Min Woong August 18, 2005 Lee /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**√** M 2□ F Months Days Hours Yrs. Director 216-62-8785 63 S. Korea 1942 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at 1 ☐ Yes 2 🛣 No Maryland Baltimore Directo Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 939 Ellendale drive 21286 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Completed by Specify 3 ☐ Widowed 4 ☐ Divorced Asian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 owner retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Chang Yong Lee Yong Α. Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is eny injury or other tra QDG0. 268 West Dryden St. -315, Glendale, CA 91202 Michael Lee- son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park 8-20-2005 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP. 21. Signature of Funeral Service Licensee 7250 Washington Blvd., Flkridge, MD shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CANCER plans /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intrinsitate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Box 68760, resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ certificete has been sign rector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed 1 ☐ Yes 2 No 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital or to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charle St. Bults and Z1208 BMC 6761 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 2 2005 Registrar DHMH 17 Rev 1/2001

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		For State	State of Ma		partment of hertificate of			0000	27200
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Physic	ian	6.2044	1				Month /	Day Year	1.40 pm
/Medi		4a. Facility Name (If not institution, give	street and number)		4b. City. Town, o	or Location of Death		4d County of Dea	
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Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthda	v) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign
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arylar show	<u>_</u>	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits 1 ☐ Yes 2√☐ No
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ler de	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		I. Was Decedent of I If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, Whi	le, etc.
l', or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: W	ite
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	To	George Laur					•	_	,
2 shot and A is ma		19a. Informant's Name/Relationship (7	ype, Print)	19b. Ma	iling Address (Street	and Number or Rui	ral Route Number,	City or Town, State,	Zip Code)
s 1 and 2 should if Health and Mer item 27 is marke other traumatic		Margaret Laur/wif	e	8000) Crainmon	nt West G	len Burni	ie, MD 210	61
	-	20a. Method of Disposition	D	20b. Place of Dis	position (Name of ematory or other pla		Date 2	20c. Location - City or	Town, State
		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☒ Other (Specify			,				
permit. Page Department of Important: If sny injury or once.		21. Signature of Foneral Service Licen Ronald S.	Wade, Dar			tomy Board		Baltimore	Street
Cityen (M)		Za. Pel 1. Enter the disease, or comp	lications that caused		Baltimore			net .	Approximate
		shock, or heart failure. List only	one cause on each line	9.	The the mode of dyl	g, such as cardiac	or respiratory arre	731,	Interval Between Onset and Death
hysician		Immediate Cause (Final disease or condition resulting in death)	a. Bra	15 //	12(05/0	2 - 5			10/04
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has le 2	Ę						autops	v prior to	completion of cause of
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this ald di	2	1 Yes 2 No 27. Manner of Death	1 🗆 Inpatier	t 2 ER/Outpati	ent 3 DOA	4 Vivursing Ho		nce 6 Other (Spe	city)
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	72 hours after death with the Maryland natural; or Items 23a or 28a-f show deat End., or must be notified at		10a. State 10b. County		, Town or Lo	cation	,			10d. Inside City Limits
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ore,	of Heal		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of natory or other place	Da	ite 200	Location - City or	Town, State
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Balt	permit. Pa Departmen Important: any injury once.		21. Signature Funeral Service Licensee	tell	14	Name and Address ARTIXY M 527 har	ss of Facility 57- ILLER - 57- FOD RD. 1	ella pun- 30 bto. M	21234	4 CHTD.
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death use on each line.						Approximate Interval Between Onset and Death
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Division	i i i i i	Certification:	4 Homicide determined	Be. Place of Infury - At ho building, etc. (Specify		eet, factory, office	2	8f. Location (Street City or Town, St	and Number or Hu ate)	irai Houte Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edicai C	(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
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36 0	Director		219-50-0397	112 M 2 □ F		58Yrs.	Months	Days	Hours	IVIIII,	1 1 - 1 5	5-46	5	MD	try)	
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	tel or A rs after el Direc ed in by	Cer			rg. otc. (open	home					2414 11			lhm	ore, Mi	2
	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in b		(Check only 2 X Medical	ng Physician: To the Examiner: On the ba	best of my kn	owledge, deat	n occurred a	at the time	e, date an	d place, a	and due to the	cause(s)	and manne	ar as sta	ited	
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54	Sta	ato.	31. Date filed (Month, Day, Year	2110	egistrar's Sign			LULL	,	חמד	criiore,	ridL	утани	4.	L4U L	
	Registi	- 1	AUG 2 5		-	IK GO	and I									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Harry Dawson Mitchell, III 2005 August 10:36a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y April 20 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** X□M 2□F 216-20-2403 79 1926 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or Itams 23a or 28a-f show the Modical Exemples must be notified at Md Carroll Finksburg 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2310 Pheasant Run Drive 21048 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (∑Yes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 ☐ No Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shields Rubber Corp. Elementary/Secondary (0-12) College (1-4or 5+) sales manager other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Harry Dawson Mitchell Jr. Elizabeth Urban 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jean L. Mitchell (spouse) 2310 Pheasant Run Dr., Finksburg, Md 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md ' 4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery 8-22-05 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Duar Vacco P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that is sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HRAVIC CRSTRUCTIVE PULMOUALY DOERSE **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit The law requires that the death certificate be executed signed by the attending physicien and Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown Completed should been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 \(\text{No} \) 1 Yes 2 No 1 TYes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 200 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 31660 19/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue WESMINSTER MARYIANO 2115 32. Registrar's Signature 31. Date filed (Month, State 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			1 - State Registrar	/laryland / I		artment rtificate			and M	•	giene Reg. No 20	05	27397
	Physic		1. Decedent's Name (First, Middle, Last) Charles B. Moran Jr.							2. Date of Dea Month August	Day	Year D	3. Time of Death 5:11am M
	/Medi Examii		4a. Facility Name (If not institution, give street and number Southern Maryland Hospit	*			own, or	Location o	f Death		4c. County of	of Death	
	Funeral Director		5. Social Security Number 220–72–2912 6. Sex 154 M 2 F	nge (In yrs. last bi	irthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birti (Month, Day Feb • 25	1950	9. Birthi Cour Pott	place (State or Foreign ntry) SVILLE, PA
	e Maryland a-f show illied at	ctor	10a. State 10b. County Prince Georges	10c. City, Tow Fort		sh i ngt	on						10d. Inside City Limits
	th with the 23a or 28 Ist be no	al Director	109. Street and Number 10710 Riverview Road			10f. Zip (Code 10744	1			10g. Citizen of W USA	hat Cour	ntry?
9800	be filed within 72 hours after death with the Maryland tal Hygiene. Additional tall than "netural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes, Give Year or Dates	;? (No	1	Was Deceder f Yes, special		spanic Orig n, Mexican Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)	14. Race Black Specify:	, White,	can Indian, etc. ite
Maryland 21215-0036	filed within 72 h Hygiene. other than "netu ant, Ihe Maylcal	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or		(Give	dent's Usual kind of work DO NOT use Labo	done di retired)	urina most	of workin	ng	16b. Kind of Bus		
yland	should ba filed within and Mental Hygiene. s markad other than umatic event, the M	To Be	17. Father's Name (First, Middle, Last) Charles B. Moran Sr.					I	Haze1	L M. Be		,	
, Mar	- a s		19a. Informant's Name/Relationship (Type, Print) Hazel Moran / Mother	196	o. Mailir 2200	g Address (Firs	Street a	nd Number 'enue	Pott	Route Number	r, City or Town, S , PA 1790	State, Zip)1	Code)
Baltimore,	permit. Pagas 1 and 2 Department of Health Importent: if item 27 I any injury or othar tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	9	ry, cren	sition (Name natory or oth metery	e of ner place	' A	ugust 2005	24,	20c. Location - C Pottsvill		wn, State
Ball	Depart Depart Import any inj		21. Signature of Foneral Service Licensee			1501 1	es L. Bast 1	Steve Fort A	ns Fu ve. B	neral Hor altimore	MD 21230		
	Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Underlying that initiated events c.	s a consequence	0f):	w S	of dying	, such as c	ardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
P.O. Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	e of pregnancy 2	3 - 5 -	Ectopic prec	cify)				23d. Date Mont	h	Ďay Year
Records,	w requiras that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death	out not resulting in	n the un			in Part I.		23e. Did tob		ute to th	e cause of death? ably 4 Unknown
	The law ate has b page 2 s	e Completed	25. Was case referred to medical	heroi	de T	Vem	ス 			24a. Was a autops perform	ned? pri	or to con ath?	osy findings available appletion of cause of
o	is di	ToB	examiner? 1 Yes 2 No	ury (28b. T	tpatient Time of njury		Other c. Injury a Work?	4 □ Nurs	sing Home		ence 6 □Other ow injury occurred)
	pitet or Attenous after death surs after death seel Director: filled in by that	l Certification:	4 Fornicide building, e	jury - At home, fai tc. <i>(Specify)</i>						City or Town			
	To the Hospitel or Attending Prwilin 24 hours attended in To the Funerel Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st 29b. Signature and title Certifier	or examination and	, death d/or inv	estigation, in	the time my opin	nion, death	place, an occurred	at the time, da	ate and place, and Date signed (d due to	the cause(s)
1	5		39. Name and organises of person who completed gause of c	death (Item 23a) (Туре, Р	Print)	76	563	30		_87/	9(0	5
	l Sta	te	Armito Souce atl	6402 S rar's Signature	5. (vair	Hw	9 4	pph	Ma	rbow	m	020772
	Registra	ar	AUG 2 2 2005	in St.	AD	200							

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	sicia edica		LADAWN	Mytt	ANN	AD			AUGUST	Day Year	- 11 7 4 11 14
	mine	er	4a. Facility Name (If not institution,	give street and number	er)		4b. City, Town, o	or Location of Death	h	4c. County of De	
<i>8</i> ,-			UNIV OF MARY		DICAL			ALTIMO:			TIMORE
Fune Direct			5. Social Security Number none	6. Sex 7 1 ☐ M 2 ☑ F	nge (in yrs.	last birthda Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug 4, 2)	005 Ma	irthplace (State or Foreign Country) .ry.Land
ס			Usual Residence of Decedent				<u> </u>		, ,		
anylar		_	10a. State 10b. County		10c. Cit	ty, Town or					10d. Inside City Limits 1 √2 Yes 2 □ No
the M 28e-f		Director	MD 10e. Street and Number			Ва	ltimore 10f. Zip Code		10	- Citizen of Milhes	A1
with			4219 Eldone Ro	ad			Tor. Zip Code	21229	10	g. Citizen of What (USA	Country !
ING 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. And other than "natural", or tlems 23a or 28e-1 show awant the Madeul Everyles may be possibled as and the Madeul Everyles must be possibled as		Funeral	11. Marital Status	12. Was Decede		.S. 13	3. Was Decedent of H If Yes, specify Cub:		pecify Yes or No-	14. Race - An	nerican Indian,
ter ter		E I	1 Never Married 2 ☐ Marrie	Armed Force od 1 Tyes 2 1 If Yes, Give			1 ☐ Yes 2√2 No	an, Mexican, Puert Specify:	o Hican, etc.)	Black, Wh	
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re, Maryl6 s 1 and 2 should of Health and Mer tiem 27 is marke			19a. Informant's Name/Relationshi				iling Address (Street				Zip Code)
C, lan Heal			University of M 20a. Method of Disposition	d Hospital	20b. F		S. Greene position (Name of	Street I		MD 212 Oc. Location - City of	
Pages nent of nut: If it			1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☑ Other (Sp.	3 □Removal from Sta	te C	semetery, cr	ematory or other place	CB)		or Location Oily o	, rown, state
	78	1					22. Name and Addre	ss of Facility	1 (55 ** *		a
Departs Departs Imports	8		21. Signature of Forest Service Ronald S	wade Di	regtor	r	22.Name and Addre Late Anat Saltimore,	omy Board	1 655 W. I	Baltimore	Street
1			23a. Part1. Enter the disease, or shock, ir heart failure. List o	omp cations hat aus	ed the deat	h. Do not e	inter the mode of dyir	ng, such as cardiac	or respiratory arres	it,	Approximate Interval Between
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uted I		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	LARC			MALOCE	F			
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GE Illica		Physician/Med	IF FEMALE:								
BOX sath cert attendin for use		lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 Live birth 4 Pregnant	2 Feta	death 3	Ectopic pregnancy	/		23d. Date of do Month	elivery Day Year
. 0 0 0		yslc	1 □ Yes 2 🗖 No 9 □ Unknown	9 Unknown		eath 3	□ Other (specify) _				
Hecords, P.O. The law requires that the tens been signed by the base 2 should be detached.	, ,	by Pr	Part II. Other significant condition	ns contributing to death	but not res	ulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
cords, wrequires been sign									1 🗆 Yes	2 □ No 3 □ F	Probably 4 Unknown
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Of VITal Physician: The This certificate and director, page		Be	25. Was case referred to medical examiner?	Hospital:			(0)		th (Check only one)		
this at di		0	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of in		ER/Outpati 28b. Time	ent 3 DOA Oth	4 - Nursing H	ome 5 Residen- 28d. Describe how		ecify)
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Ltal or rs after Dir.		Cer	4 - Nominoido	building,	etc. (Specif	y /		1	City of Town,	State)	
DIVI To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		edical	(Check only 2 Medical E	Physician: To the be- xaminer: On the basis	of examina	wledge, deation and/or	ath occurred at the tir	ne, date and place, pinion, death occu	, and due to the cau	se(s) and manner a e and place, and du	as stated. le to the cause(s)
To the within 2 To the complet		Med	one) 29b. Signature and title of certifier	and manner	stated.		29c. Licens			I. Date signed (Mor	
¥ ¥ ¥ 8			Dalwa VK	Ende 1	11		וחס	16/075	3 1	18/119/1	1095
		-	30. Name and address of person w	no completed cause o	death (Iten	n 23a) (Type	e, Print) 22	South	Greane-S	treet V	VUJ NEWILR
			Adona Wor	wdi.M.	U	Bal	ti more		21201	incur , the	WOIT IN TIVE
ne sp	Stat	2.	31. Date filed (Month, Day, Year) AUG 2 2	2005 32. F egis	strar's Signa	iture	poole	J			
Reg	istra		HOU & &	1		- //					

Amend item/5, per FH, G847, 9/6/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** NELSON 01:59 PM AUGUST 19 2005 YORMAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CENTER BALTIMORE N/A HARBOR HOSPITAL 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) 1928 Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 220-86-8487 220-22-7290 Usual Residence of Decedent Yrs. MD Director 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a. State 23a or 28e-f show treumatic event, the Medical Exercitivat result by notified at Baltimore City N/A MD Yes 2 No Completed by Funeral Director 10f. Zip Code 21230 10g. Citizen of What Country? 10e. Street and Number USA 1819 Covington Street filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No Army If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) tems 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ò white 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "netural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ô Checker Manufacturing 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othn any injury or other treumatic event 2008. Be Emma Walton Sigward Nelson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1819 Covington Street, Baltimore MD 21230 Rosalie Nelson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Cemtery 08/23, 2005 Baltimore MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensea Victor P. Doda 22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.), 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPOVENTILATION SYNDROME Physician OBESITY disease or condition resulting in death) /Medical Examiner WKS ELEVATION MI, NON ST ELEVATION MI ST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner The law requires that the death certificate be executed use as the burial-transit IWK ACUTE RENAL FAILURE Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown þ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown DIABETES page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No VASCULAR DISEASE PERIPHERAL 24a. Was an autopsy performed? SLEEP 2 1 No OBSTRUCTIVE 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 [Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n 24 hou. the Funerel Directory filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 Ruth, RES DOU AUGUST 19 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 ST, BALTIMORE MD 21225 NOTHAGNI HANOVER 32. Registar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

AUG 2

2005

			For Amend Item 8	State of Maryland per In 6846 8-3	1Department of F Cas Certificate of	Health and M <i>Death</i>	ientai Hygie Reg	2005	27400
	**-*		Decedent's Name (First, Middle, La	st)			2. Date of Death		3. Time of Death
	Physicia		CliFFORD	EMIL	0/500	1 5R.	August	Day Year	- 8:10 PM
	/Medic Examin		4a. Facility Name (If not institution, giv			or Location of Death	17-501	4c. County of Dea	th
1	_ Xuiiiii	CI.	3506 MAR	y Avenue	BA	HIMORE			
	Funeral		5. Social Security Number 6. 5	7. Age (In yrs. last	birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	2-12-1920	thplace (State or Foreign buntry)
	Director		505-12-9834	XM 2□F 84	Yrs. Months Days	Hours Min.	DEC 16	MZC NE	BRASKA
	ס		Usual Residence of Decedent						1
	ylan		10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	Ma 6-18	5	NACHAND	BAIT	Trione				1 ZYes 2 □ No
	h the	ire	10e. Street and Number	1	10f. Zip Code	21611	100	g. Citizen of What Co	ountry?
	th wi	by Funeral Director	3506 17A	my Aveny	e .	21214		U-5	-A-
	dea arms	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	or it	F	1 Never Married 2 Married	1 No lf Yes, Give	1 ☐ Yes 2 X No	Specify:		Specify:	1.17
5-0036	within 72 hours after death with the Maryland ene. Than "natural", or tiems 23a or 28e-f show ha Medical Examinat must be notitied at	db	3 Addidowed 4 ☐ Divorced	Year or Dates:					DHITE
5	72 h	Completed	15. Decedent's E (Specify only highest gr		 Decedent's Usual Occup (Give kind of work done) 	during most of worki	ing 16	b. Kind of Business	Andustry
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121	filed withi Hygiene. other than	ပ္ပ	17. Father's Name (First, Middle, Last		<u> </u>	18. Mother's Name	/Firet Middle Ma	iden Sumame)	,
S C	be fi	Be	F. Pallier's Ivallie (First, Ivilouie, Last	10	Ison	A	-	-	achers
<u>₹</u>	sould be Mental narked o	2	LMIL	Clima Cariati	9b. Mailing Address (Street	and Number of Plus	Pouto Number (
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Martla Hygiene. If Health and Martla Hygiene a statural, or Items 23a or 28e-f show filem 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event. The Medical Francisca must be notified at		19a. Informant's Name/Relationship	To - Saw	30. Mailing Address (Street	La.	-	1 /	MD 21236
-	1 and 2 Health em 27 other tra		20a. Method of Disposition		of Disposition (Name of	HUCN		C. Location - City or	
ō	Pages nent of H int: If Ite		1 🗆 Burial 2 🗷 Cremation 3	Removal from State	itery, crematory or other pla	ce)			
Ę	Pa tmen tant: ijury		' 4 □ Donation 5 □ Other (Speci		IVIEW CREH	ATORY HUG	22,05	Altimor	e Maxy mas
Baltimore	permit. Pages 1 ar Department of Hea Important: If Item any injury or othe once.		21. Signature of Euneral Service Lice	n998	1+ARTLEY	MILLER-	Stelli	4 Funera	1 Home CHTD
	403 e Q		61970	P. C. Alexandra de Maria					HD 21234 Approximate
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	o not enter the mode of dyl	ng, such as cardiac o	or respiratory arres	ι,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. COVNGVY Due to (or as a donsequence	Intery Diser	شو			years
	/Medical Examiner		resulting in death)	A		. ~			
		_	Sequentially list conditions,	b. Artho Sclero H		scol an	1718656		yars
./	ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2 /	56 01/.				
V	and and I-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a consequence	ce of):				900-5
760,	cate be executed physician and the burial-transit	aiE							
æ	cate be physicia the bur	dicai	•	d					
9 x	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnancy				23d. Date of de	in/en/
Box	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3 Ectopic pregnanc	у		Month	Day Year
P.O.	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	Januar (speeny)				
	that the sad by detact	Ph.	Part II. Other significent conditions	contributing to death but not resultin	g in the underlying cause gr	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,	sign d be	Completed by	Alzeheimen	distin			1 ☐ Yes	2 No 3	obably 4 Unknown
Ö	requ been shoul	ete					24a. Was an	24h Wara ai	stoney findings available
3ec	e law has l	шþ					autopsy	prior to death?	utopsy findings available completion of cause of
1				Ţ			1 Yes 2€	∃No 1 ☐ Yes	2 No
Zi.	Physician: The lav this certificate has ral director, page 2 :	Be	25. Was case referred to medical examiner?	Hospital:	Ott		(Check only one)		
of	physithis caldir	10	1 Yes 2 No	1 Inpatient 2 EH		1er: 4 ☐ Nursing Ho	me 5 Residen		city)
\subseteq	6		27. Manner of Death	(Month, Day Year)	Injury Wo	rk? Yes 2 No	200. Describe now	injury occurred	
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		•	1- For State of Maryland /		tment of He			giene Reg. 2005	27401
	*	優	Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
	Physici /Medic	_	Dona tark				Augus	t 16, 200	5 9:50p M
1	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	Death	4c. County of D	eath
*	· 经营业。		Future Care Homewood		Baltim		411-		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last to the security Number 1 🔀 M 2 🗆 F		If Under 1 Year Months Days	Hours	Min. (Month, Da	v. Year)	Birthplace (State or Foreign Country)
	Director		214-13-3113 65 Usual Residence of Decedent	11.0			Feb. 5	, 1940	Korea
	/land		10a. State 10b. County 10c. City, To	own or Loca	ation				10d. Inside City Limits
	Mar Be-f st	ţo	Maryland Bal	ltimor	ce				1X Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	23E		11 West 20th St., Apt 90		21218			Korea	
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Wa	as Decedent of His Yes, specify Cubar	spanic Origi n, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	- 14. Race - A Black, W	merican Indian, hite, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	10	☐ Yes 2 🔀 No	Specify:		Specify:	Asian
9	72 hours after death with the Maryland naturel', or Items 23s or 28e-f show disal Examiret - wat be multikul at		15. Decedent's Education 16	6a. Decede	nt's Usual Occupa	tion		16b, Kind of Busine	ss/Industry
212	within 72 ene. then "na	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. DC	ind of work done di O NOT use retired)	uring most (of working		
21	e filed within al Hygiene. I other then ' vent, Ire Mo	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Carpe				Self-emp	ployed
Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. ed other then. event, the Micdical Examiner out to multified at	Be	17. Father's Name (First, Middle, Last)			18. Mother	s Name (First, Middle,	Maiden Sumame)	
Z	2 should be a and Mental is marked o	ို	Dong Y. Park	10h Mailia	Address (Ctrests		N. Kim	City or Town State	7 Tin Cadal
Mar	12 sh h and 7 is m treum			196. Mailing	,		or Rural Route Numbe nor, Marri		
e,	ges 1 and 2 should tof Health and Mer If item 27 is marke or other treumatic		20a Method of Disposition 20b. Place	e of Disposit	tion (Name of		Date	20c. Location - City	
nor	ages int of t: If it		1 DAurial 2 Cremation 3 Removal from State	-	atory`or other place		8-19-2005	Marriotts	sville, MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		21. Signature of Funeral Service Licensee	-			n Funeral		
Ã	Depa Impo any is		> helgh				n Blvd, El		
	*		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician	T j	Immediate Cause (Final disease or condition		7	7			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as y onsequence	ice of):		_	- 0		
60	Examiner		Sequentially list conditions, b.	<u> </u>	evel	(uluse		
/	be.	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2001).	and so	D	uluse seare		
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8760	icate be executed physician and s the burial-transit	dicai I	(Drabet	J->					
9	tificat ng ph) as th	ledi	I F F F M F						
Вох	death certifica e attending ph id for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea		ctopic pregnancy			23d. Date of Month	delivery Day Year
O. E	0 0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	n 5□0	Other (specify)			Widitii	Day Tou.
σ.	that the de ad by the detached		Part II. Other significant conditions contributing to death but not resulting	na in the und	lerivino cause give	n in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ds,	Se G	d by		cid			1 🗆 Y	/es 2 □ No 3 🖺	Frobably 4 Unknown
Sor	> 11 0	ompieted	Hadan a Culom		odlen	. 0	24a. Was	an 24b. Were	autopsy findings available
Re	The law ate has b page 2 st	mo	Class Obstach	182	200-1-004	<u> </u>		rmed? death	to completion of cause of ? 'es 2□ No
ta	icien: Th certificate ector, pag	e C	25. Was case referred to medical		andra	26. Place of	of Death (Check only of		63 21110
Ţ	S S	To B	examiner? 1 Yes 2 No	VOutpatient	3□ DOA Othe	r: 4 Hours	sing Home 5 🗆 Resid	ience 6 Other (S	pecify)
0 0	ng Pt fter th		27. Manner of Death 1 ☐ Matural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury Work			now injury occurred	
Sio	Attending ir death. ector: Atterby the fune	cati	2 Accident investigation			′es 2 □ N		Street and Number or	Burni Bauta Mumbar
Division of Vital Record	ol or Attend after death Director: /	Certification:	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	, rarm, stree	et, factory, office		City or Tow		Rural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physicien: To the best of my knowled	dge, death o	occurred at the time	e, date and	place, and due to the	cause(s) and manner	as stated.
	1 24 h	edicai	(Check only one) 2 Medicel Exeminer: On the basis of examination and manner stated.	and/or inve	stigation, in my op	inion, death	occurred at the time, o	date and place, and o	lue to the cause(s)
	To the Tro the Tro the Tro the Comp	Me	29b. Signature and title of certifier		29c. License			29d. Date signed (Mo	onth, Day, Year)
			> person my		_	146	, 4	8118	05
	8		30. Name and address of person who completed cause of death (Item 23s SHORING ALL SHORING STATES ALL SHORING	ia) (Type, Pr	5. Ente	mo	St mite	308, 130	Itume mp 2/20
VE	Sta Registr		31. Date filed (Month, Day Year) AUG 2 2 2005 September 2 2 2005	15 1	porte			,	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death 3. Time of Delatir 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** JOSEPH PINIECKI 3:13 A M PETER August 21 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BAYVIEW Medicate Cen.
6. Sex 7. Age (In yrs. last birthday) Johns Hopkins If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Hours 1)2 M 2 □ F 9 5 MALY/AND Director Det 14 1945 215-46-5593 Usual Residence of Deceden with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 27 is marked other than "natural", or itams 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BAltIMORE MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4.5.A SASSAFRAS KOAD 21221 331 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 □ No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: MARINES Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Faderal Armored Etpros DRIVER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **YINIECKI** Peter SR. MALLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) item 27 i 331 SASSAFAS KOAD SSex MARYLAND 21221 Joseph A. YINI 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Jesus Centrast 25,05 * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Tosus N. Zpunino 21. Signature Fuperal Service Licensee JR. 263 5. Conkling Street Balto. 21224 Part 1. Enter the disease, or compressions that caused the death. Do not enter the mode of dying, such as lardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VCPEIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 🗆 No 1 Yes 2 2 No 1 TYes or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner' Hospital: 1 SInpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Director. 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 T Homicide within 24 hours a 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 21, 2005 RES-000 Der Sengupt mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEVI SENGUPTA MD. JOHNS HOPMING BAYMEN, 4940 EASTERN AVENUE, BALTIMORE, MD 2/224 31. Date filed (Month, Day, Year) AUG 2 2 State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 18 Day **Physician** Da1e Robertson 2005 August 5:40a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7091 Brangles Road Carrol1 Marriottsville 8. Date of Birth (Month, Day, Year) Feh 11 1943 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** PA 62 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-1 show the Medical Examiner cust be notified at Md Marriottsville 1 Yes 2 No Carroll Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code ö 7091 Brangles Road 21104 USA 238 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? natural', or Itame 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry parmit. Pages 1 and 2 should be tilad within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event. The Mixel 0003. College (1-4or 5+) +8 Elementary/Secondary (0-12) legal Attornev 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dale Reid Margaret Schilling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blair B. Reid (spouse) 7091 Brangles Rd., Marriottsville, Md 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) All County Cremation | 8-19-05 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses P.O. Box 195 Sykesville, Md

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 195 Sykesville, Md 21784 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUROMUSCULAR **Physician** /Medical Due to (or as a consequence of) Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine tor use as the burial-transit FE SPIRATOR and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown baen signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 100 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 X No 5 Residence 6 Other (Specify) 2 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Atter Hospitel or Attending 1 Accident Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation fillad in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel within 24 hours a To the Funeral C Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatur and title of cert 29c. License number 42827 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) OWINGS MILLS CROSSNOADS DR 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State meles AUG 2 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 12.55 Physician Loher 5 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, giv eet end number Examiner Ann Arnold If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Year) **X**M 2□ F 220-30-7455 0 Yrs. Director MKHOWL Usuel Residence of Decedent parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haaith and Mental Hygiena. Important: If them 27 ie marked other than "nature" any injury or other traumatic executions. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ¥ Yes 2 No Anh Funeral Director Yhol 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number u ·s A 21012 305 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 2 THE I ☐ Yes 2 If Yes, Give 1 ☐ Yes 2 ☐ NO Specify: Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) shipyard 0 6 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Fether's Neme (First, Middle, Last) Robert Ryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) 21012 Future Care Chesapeake 305 College Parkway Arnold, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20e. Method of Disposition cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4□Donation 5型Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee
Ronald S. Wade Director 21201 Baltimore, MD man 23a. Per 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical months F__miner Due to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical Examiner ed by the attending physician and datached for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate ba axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown LEMACE 1 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 Mills within 24 hours after death.

To the Funerel Director: After this certifice completaly filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Shursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certified D-40251 8/17/2005 Juite 208 25 Haspited 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) DR. OCHANCI WD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar AUG 2 2 2005

DHMH 16 Rev 6/95

Cobut

			State	of Maryland / [Department of Health a		
		1	For State Registrar		Certificate of Death		12005 27405
	Physicia	an	1. Decedent's Name (First, Middle, Last)	C		2. Date of Death Month	Day Year 3. Time of Death
	/Medic		MARY E	STORTZ		08	16 2005 10:33 PM
	Examin	er	4a. Facility Name (If not institution, give street and	1_	4b. City, Town, or Location of	AID	4c. County of Death
	Funeral		Good Samaritan H 5. Social Security Number 6. Sex	7. Age (In vrs. last bir	thday) It Under 1 Year If Under 2		9. Birthplace (State or Foreign Country)
	Director		219-28-8879 10M 27	73	Yrs. Months Days Hours	Min. (Month, Day,)	1,1931 Country) M.S.
	pue *	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
	Manyla 1 sho	ō	MANNA		BALTIMORE		12 Yes 2 □ No
	r 28a-	Director	10e. Street and Number		10f. Zip Code	100	G. Citizen of What Country?
	th with	al D	3114 GRINDO	N AVR	21	214	U. S.A.
	r dea	Funeral	Ame	Decedent Ever in U.S. d Forces?	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs afte	by Fi	_ If Yes	es 2 No , Give or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Juhite
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or ltems 23s or 28s-1 show the Marical Examiner must be multied at		15. Decedent's Education	16a	. Decedent's Usual Occupation	16	6b. Kind of Business/Industry
215	thin 7	Completed	(Specify only highest grade complex Elementary/Secondary (0-12) Collection	ge (1:4or 5+)	(Give kind of work done during most life. DO NOT use retired)		11.
121	Hygien Hygien Ither th		17 Fatharia Name (First Middle / act)	NA	Homemake	s Name (First, Middle, Ma	Home,
anc	d be fi) Be	17. Father's Name (First, Middle, Last)		5 n	iti Sui	VCLAI
Z	shouk nd Me mark umatic	P	19a. Informant's Name/Relationship (Type, Print)	196	o. Mailing Address (Street and Number	r or Rural Route Number,	
	and 2 salth a n 27 ls		EyDie K. STOR	TZ 3	1131 MANAYUNK	Ave. Phi	LeDelphia PA 19128
ore,	of He of He fitem r oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal f	20b. Place o cemete	f Disposition (Name of ry, crematory or other place)	1 .	Oc. Location - City or Town, State
ij	Pages Iment of tant: If it jury or o		* 4 □Donation 5 □ Other (Specify)	BAYL	new Clemanois	103	Balto. Ms.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or Items 23s or 28a-1 show any Injury or other traumatic event, If a Medical Examinet must be notified at once.		21. Signature of Funeral Service Licensee	0.	22. Name and Address of Facility It ARTLEY MILLER	STELLA FUNE	M 21234
			23a. Part1. Enter the disease, or complications the	nat caused the death. Do	not enter the mode of dying, such as		t. Approximate
N.	Physician		shock, or heart failure. List only one cause Immediate Cause (Final		T. + seculos	0	Interval Between Onset and Death
	/Medical			seminated to (or as a consequence	Intravascular	Coagulor	Dainy
ľ	Examiner		Sequentially list conditions.	1515		·	/
/	sit sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence	of):		
<i>V</i> _	be executed sician and burial-transit	Examiner	that initiated events c	e to (or as a consequence	of):		
760,	S cia	calE					
99			IF FOMAL C.				
Box	ath cei ttendii or use	an/h	in the past 12 months?	, outcome of pregnancy ive birth 2 Petal death			23d. Date of delivery Month Day Year
0.	at the dea by the a stached fo	Physician/Med	1 Ves 2 No	regnant at time of death Inknown	5 Other (specify)		
<u>α</u>	de de		Part II. Other significant conditions contributing	to death but not resulting i	n the underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
Vital Records,	quires in signeral land be	ed by	Cardio myopathy,	Dialated		1 ☐ Yes	2 No 3 Probably 4 Wunknown
000	aw requir is been si 2 should	plet	/ ' / '			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
R		Completed				performe	death?
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?			of Death (Check only one,	
of	shys this al dii	To	1 Yes 2 No Hospital: 27. Manner of Death 28a. □			sing Home 5 Residen	
ou o	ding F h. After funer	tlon	1 Natural 5 Pending 2 Accident investigation		Time of lnjury at Work? M 1 Yes 2 □ N		rinjury occurred
Division	Atten deat ctor: y the	fica	3 Suicide 6 Could not be 28e. F	Place of Injury - At home, fa		28f. Location (Stre	et and Number or Rural Route Number,
Ö	s after s after al Dire	Certification:	4 Homicide	uilding, etc. (Specify)		City or Town,	State)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medical Examiner: On t	he basis of examination ar	e, death occurred at the time, date and nd/or investigation, in my opinion, deat	d place, and due to the cau h occurred at the time, dat	se(s) and manner as stated. e and place, and due to the cause(s)
	the Ithin 2 the Implet	Med	one) and 29b. Signature and title of certifier	manner stated.	29c. License number	290	d. Date signed (Month, Day, Year)
	F 3 F 8		HARWAY MARWAY	GOCT M.J	D. RESOOD		08,18,2005
•	.0		30. Name and Addless of person who completed	cause of death (Item 23a)		1 0 0	1 0 11
	10		ABOVEERGI Good S	amaritan Ho	spital, 5601 Loc	ch Kaven Blvo	1, Balto., MD 21239
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	A disconnection		
Di	Registr		AUG 2 2 2005	Been &	Sparke		
	1001 17 DEV 1/20	VUI					

Stortz, Mary

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last **Physician** Car /Medical 4b. City Fown, or Pocation of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner OWG OVIEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2XF Yrs. 94 Maryland Director 578-28-6991 05/24/1911 Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Marylend nent of Health end Mentel Hygiene. 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f shov other traumatic event, the Medical Examiner must be notified at Yes 2□No MD Completed by Funeral Director Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 6334 Cedar Lane 21044 itетs 23a USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Ž(Ž)No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0020 ŏ Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s and Mentel I Glenn Arden Seaman, Sr. Laura Hicks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 I William Stiles (husband) 6336 Cedar Lane #172 Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ò 4 ☐ Donation 5 ☐ Other (Specify) Louis Cemetery 08/22/2005 Clarksville, MD 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licenses 5555 Twin Knolls Rd. Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner edical Certification: To Be Completed by Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the deeth certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that in lated as a condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the conditions, and the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the condition of the con Division of Vital Records, P.O. Box 68760, Due to for as a consequence of resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? eumon, 9 24 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No within 24 hours efter deeth.

To the Funeral Director: After this completely filled in by the funeral 28c. tnjury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manger of Death 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number title of certifie 29b. Signature and who completed cause of death (Item 23e) (Type, Print), 10805 Gay 31. Dete filed (Month, Day, Year) 32. Regionar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** August 20 2005 :34 P M Senseney Jr. Ellsworth /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** NA Johns Hopkins Bayview Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F Yrs 1934 Director Maryland 219-28-0799 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show other treumatic event, the Medical Examinar har must be notified at 1 ☐ Yes 2 No Baltimore Dunda1k Maryland Director 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number ŏ U.S.A. 21222 'natural', or Iteme 23a 8028 Gray Haven Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after _XYes 2 □ No Yes, Give 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driner Penske Logistics 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ethel Ellsworth Senseney Sr. Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8028 Gray Haven Road Baltimore, Maryland 21222 Virginia Senseney (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) August 22 Baltimore, Maryland Bayview Crematory Inc. 22. Name and Address of Fac 2005 21. Signature of Funeral Service W. Dabrowski/Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death 233 Part1. Inter the disease, or complication shock, or heart failure. List only one call Immediate Cause (Final **Physician** disease or condition resulting in death) 3 Months Liver Failure /Medical Due to (or as a consequence of). Examiner 1 Day Cryptogenic Cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran and Due to (or as a consequence of): P.O. Box 68760, the attending physician pe Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ þ 1 ☐ Yes 🌠 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed? 2√2 No 1 ☐ Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifice funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) **X**□ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 3□ DOA Certification: To 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3408> M. D, AUGUST 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN, HORKING BAYVIEL MEDICAL CENTER Mathias HOLDHOFF, M.D. 4940 EAITERN AVENUE, BALTIMORE, MD 21224 31. Date filed (Month, Oay, Year) 32. Registrar's Signature State Registrar Blow & Sparke AUG 2 2 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	•	epartmen C <i>ertificat</i>				gierie Reg. No.	200	C /	77100
İ			<u>_</u>	ne (First, Middle, Las	it)					2. Date of Dea	ath Day	Yea	3.1	ime/of Death
	Physicia /Medic		TOMM			SN	ITH			AUGUST	17	2 200		0:19 PM
	Examin	er			street and number)				ocation of Death	()		County of De		E
			NONTH 5. Social Security I		SPITAC ex 7. Age	(In yrs. last birth	day) If Under	1 Year	Il Under 24 Hrs.	9 Date of Bid	b			State or Foreign
	Funeral Director		036-22-		QM 2□ F	70 Y	rs. Months	Days	Hours Min.	(Month, Da Sept. 6	y, rear)	34 Al	abam	a
	pu *		Usual Residence of	of Decedent 10b. County		10c. City, Town	or Location						10d. In	side City Limits
	ith the Marylar or 28a-f ehow	or	Md.	Baltimo	re		sterst	own					И	Yes 2 □ No
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	th with	ai D	12020 R	iesterst	own Rd.			136			US			
020	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then than 40 marked other than "natural", or Items 23a or 28a-f show other translated the motified at other traumatic event, the Machael Examinar mast be notified at	by Funeral Director		med 2☐ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:		13. Was Dece if Yes, spe 1 \(\sum \) Yes		panic Origin? (Sp , Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)		14. Race - Ar Black, WI Specify: B	nite, etc.	
5	72 ho natur	eted	(Spe	15. Decedent's Ed	ducation de completed)	16a.	Decedent's Usu (Give kind of wo	al Occupat rk done du	ion uring most of work	ung	16b. Kir	nd of Busines	s/Industry	
7	within ane. than	Completed	Elementary/Sec	condary (0-12)	College (1-4or 5	- 1	<i>™</i> ®. <i>DO NOT u</i> urnitu				Pri	vate	Indu	stry
7	illed withir Hygiene. other then		12 17. Father's Name	(First, Middle, Last)					18. Mother's Nam					
0	should be ad Mental marked c	To Be	John	B. Whets	stone				Susie N	Mae Ark	ee	Whets	tone	<u> </u>
Mary	nd 2 shou aith and N 27 is ma r trauma		19a. Informant's M Yolanda	Name/Relationship (_{Турө, Print)} xins (Dau	ght) 45	Mailing Address 07 Lyo	ns R	un Cir.	al Route Number, #203 C	er, City or Win	r Town, State gs Mi	, Zip Code 11s,)21117 Md
more,	Pages 1 a nent of Hei int: If item iry or othe		20a. Method of Dis 1 Burial 2 4 Donation		Removal from State	20b. Place of cemeters Mt. Z	Disposition (Nai v, crematory or c ion Ce	ne of other place mete	ry 8/19	Date 9/2005		cation - City dsdow		
рашног	permit. Pages Department of Important: If it eny injury or o	1	21. Signature of F	Funeral Service Licer	1560				of Facility Ja rth Ave					
	4,2	(23a. Part 1. Enter	r the disease or com	plications that caused one cause on each lir	the death. Do n							Appi	oximate val Between
	Physician		Immediate Cause disease or condit	e (Final		ARY TR							Ons	et and Death
	/Medical Examiner		resulting in death				of):							
	*	10	Sequentially list of any, leading to	conditions,	b. SE Due to (or ds	a consequence of	of).							
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Ď	ificate be executed 3 physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequence o	of):							
09/90	ohysici the bu	edicai			d								-	
O. Box 6	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow	12 months? 2 □ No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s					23d. Date of o Month	delivery Day	Year
7	requires that the een signed by th nould be detache				contributing to death b			ause give	n in Part I.		obacco u Yes 2[se contribute		use of death?
Vital Records,	e law has b	ompleted by									psy ormed?/	prior t death	to complet?	ndings available ion of cause of
ē		င္ပ	25. Was case ref	erred to medical					26. Place of Dea	1 ☐ Yes		101	es 2	No
2	ysicien: is certific director,	0 8	examiner? 1 Tes 2		Hospital: 1 Thipatie	ent 2 ER/Ou	tpatient 3 D	Otho	r	ome 5 Resi		6 □Other (S	pecify)	
on or	iding Ph th. : After this funeral	tion: T	27. Manner of De 1 ☐Natural 2 ☐ Accident	5 Pending	28a. Date of Inju (Month, Da	ry 28b. T y Year) In	ime of njury M	28c. Injury Work 1 🔲 Y	at ? ′es 2 □ No	28d. Describe	how injur	y occurred		
DIVISION	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b	289. Place of inj	ury - At home, fa	rm, street, lactor	y, office		28f. Location (City or To			Rural Rou	ite Number,
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Þ,	Sta Regist	ate rar	31. Date liled (M	onth, Day, Year) AUG 2 2	2005 32. Relistr	ar's Signature	Soul	•	41.11- : 11.	. • • • •	1.3			

State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 17, _2005 **Physician** 5:00am ^M Mildred Saul L. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Millennium of Ellicott City Ellicott City If Under 1 Year If Under 24 Hrs. 5. Social Security Number 21701–2948 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 200 85 Director 01/08/1920 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int if item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at MD N/A Baltimore City Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 USA 1404 Haubert Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify: white þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George P. Atkinson Louisa A. Franz P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health ar Important: If item 27 Is any injury or other traugues. Edward P. Saul / Son 2105 Ridgemont Drive, Finksburg MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXSurial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 08/ 19/2005 Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. Charles L. St Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 new Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** end-stage Alzheimers DementiA disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 □Yes 2 🔀 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☑ No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) completely filled in by the funeral director, examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1 Deatural 5 Pending 1 🗌 Yes 2 No investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be determined 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier Wayapetnemo D 0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 -Main street, Suite 200, Reisterstown, MD. 21136 N. Si Rajapakse Mip -31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** charles, Stone th 2005 15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner AIM of Maryland Medical Center University Baltimore If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sax **Funeral** Days Hours Months Min 1**∑**M 2□F unk Jan 17, 71 Director 215-28-7450 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Nedical Examinating the notified at 1√2 Yes 2 □ No MD Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2108 Boston Street #307 21231 USA Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. unk 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk unk Be Pages 1 and 2 should be facenty of Health and Mental P is marked 20 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health item 27 i 22 S. Green Street Baltimore Street 21201 University of MD Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 0 = 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or `4 □Donation 5 ☑Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Raltimore, MD 21201 Ronald nt1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 36 hour Immediate Cause (Final disease or condition resulting in death) **Physician** Sedsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No for 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has certificate 1 ☐ Yes 2/ Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 3 0 1 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М ☐ Accident Diractor: filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours after To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State

AUG 2 2 2005

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

South Greene

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

M 16682

29d. Date signed (Month, Day, Year)

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247			Registrar 1. Decedent's Name (First, Middle, La			Crimodi	0,00	Call	2. Date of Dea	th	3. Time of Death
7	Physici		Ronald Simmons						July 1	7. 2005	8.00 P M
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7	Funeral	Ŋ	5. Social Security Number unk 6.	Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. last birthd	Months		Hours Mir	. (Month, Day		Birthplace (State or Foreign Country) unk
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
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	within 72 hours after death with the Maryland ane. than "netural", or Iteme 23a or 28e-f ehow ha Medical Examinar mual be notified at	Funerai	11. Marital Status unk	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Dece If Yes, spe	dent of Hisp orfy Cuban,	anic Origin? (Mexican, Pue	Specify Yes or No- erto Rican, etc.)		American Indian, Vhite, etc.
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	l and 2 leelth a m 27 i		O.C.M.E.	7	111 20b. Place of Di			t Balt	imore, MD	21201 20c. Location - City	or Town State
Baltimore,	Pages 1 ar nent of Hee int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [Removal from State	cemetery,	rematory or	other place)	1	5415	zoc. Location - Oily	or rown, state
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ă	death a atte	cia	in the past 12 months?	4□Pregnant a		3 ∐Ectopic p 5 ☐ Other (s				Month	Day Year
P.O.	thet the de ed by the detached	hys	9 Unknown	9□ Unknown							_
	or Attending Physicien: The law requires thet the death certific leath. Director: Atter this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	by P	Part II, Other significant conditions	contributing to death b	out not resulting in th	e underlying	cause given	in Part I.			e to the cause of death?
Division of Vital Records,	require been si should I								1 Y	es 2□No 3□	Probably 4 Unknown
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	⊢≯⊢S		TI a	11 %			OCME			July 18,	2005
			30. Name and address of person who	completed cause	death (Item 23a) (Tv		COLIE		ninvis.	cury 10,	2007
			THEODORE M	(King	, (,)		l Penn	Stree	t, Baltim	ore, Mary	land 21201
153	Sta	ite	31. Date filed (Month, Day, Year)	2. Pegistr	rar's Signature	locat.	,				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 205 AV Edward Charles Turner /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner University Specialty
5. Social Security Number 6. Sex Baltimore
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Hospital 8. Date of Birth (Month, Day, Year) 7. Åge (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 → M 2 → F Yrs 78 Dec. 6,1926 Maryland 217-20-1258 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 1 Yes 2 No Directo Maryland Baltimore Halethorpe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Willys Avenue 5545 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 1 Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ lf Yes, Give Year or Dates: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Davis and Hemphill co. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Jenny Alice Zychoff Harry Raymond Turner, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5545 Willys Ave., Halethorpe, Maryland 21227 Cora Turner- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town State 20a. Method of Disposition Date 1XX urial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 8-19-2005 Elkridge, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Fure at Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., INC. 7250 Washington Blvd., Elkridge, MD 21075 You 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3 Week Immediate Cause (Final disease or condition resulting in death) Sep 315 Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 Tes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

29c. License number

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611, S. CHAR

BALTIMORÉ

29d. Date signed (Month, Day, Year)

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Funeral

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Department of important: if any injury or gode.

Physician /Medical

Examiner

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Mary

Baltimore,

traumatic event, the Medical Examiner must be notified at

State Registrar

No. University

noleted cause of death (Item 23a).

DHMH 17 Rev 1/200

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who

			For State	State of Mary				lental Hygi	ene	
		- Arc	1 State Registrar 1. Decedent's Name (First, Middle, L	41	Ce	rtificate of	Death		g. No.2 1 1 5	271.13
п	Physic			Catherine Tho	mas			2. Date of Death Month	Day Year	(3. Time of Death)
	/Medi Examii		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	or Location of Death	Aug. 21,	2005 4c. County of Dea	2:30 a ^M
34	Xqiiiii		Westminster N		. Ctr.	Westmin			Carroll	
	Funeral Director		5. Social Security Number 6. 219–80–4478	Sex 1 □ M 2 1 7. Age (In	yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days		8. Date of Birth July 31,	Year) 918 Ma	rthplace (State or Foreign ountry Lryland
	pue *		Usual Residence of Decedent 10a, State 10b, County	100	. City, Town or Lo	cation				101 1-11-01-11
	Maryla f sho	ō	Md. Carro		Finksb					10d. Inside City Limits 1 ☐ Yes 2 No
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	th with	a D	2408 Old West	tminster Pike		210	048		U.S.A.	
21215-0036	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23s or 28a-f show any injury or other treumatic event, the Medical Eventh et must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 □ Yes 24 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
2-0	72 hor	ted	15. Decedent's (Specify only highest g	Education	16a. Dece	dent's Usual Occup	pation during most of worki	10	6b. Kind of Business	/Industry
121	ithin 38.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of working)	ing	TT-	
121	iled w tygier her th		17. Father's Name (First, Middle, Las	41	нои	sewife			Homemaker	·
Maryland	Mental H Mental H arked ot atic ever	To Be	Bernard Walls	•				n Clayton	1	
	and 2 shiralth and 2 27 is mertion mercental and 27 is mercental a		19a. Informant's Name/Relationship Pauline Higgs -				and Number or Rura			
Baltimore,	Pages 1 ament of He ant: If iten ury or oth		20a. Method of Disposition Burial 2 Cremation 3 Other (Special Content of C	□Removal from State M	b. Place of Dispo cemetery, crer eadowrid	sition (Name of matory or other pla ge Mem.	Park Aug.	24, 2005	oc. Location - City or Baltimor	Town, State
Balt	Departition of the permit of t		21. Signature of Juneral Service Lice	Oa II	Ec.	Name and Address Reis	ess of Facility uneral Cha terstown I	apel, P.A	21 os Mills.	117 Md.
	Pnysician /Medical		23a. Paf1. Enter the disease, or conshock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death)	y one cause on each line. a	death. Do not ent	er the mode of dyir	ng, such as cardiac o	or respiratory arres	it,	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a con	1 CH D					> 10 YEARS
	_ A+	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (or as a con	sequence of):					7 TO TRAKE
	tificate be executed ig physician and as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с						
30,	oe exe cian a ourial-		resulting in death) Last	Due to (or as a con	sequence of):					
68760,	physic the b	edical		d						
O. Box 6	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ f 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	ivery Day Year
ds, P	uires that signed b ld be deta	by	Part II. Other significant conditions	contributing to death but not	resulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba		o the cause of death?
Record	s been s been s should	Completed						24a. Was an		itopsy findings available
Re	The lav	шо						autopsy performe	prior to death?	completion of cause of
Vital		0	25. Was case referred to medical				26. Place of Death		INo 1 ☐ Yes	2□ No
of V	diis	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Oth	AC -		ce 6 Other (Spe	cify)
		on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea.	r) 28b. Time of Injury	28c. Injur Wor	y at 2 k?	28d. Describe how	injury occurred	
Sio	Attendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not	ne -			Yes 2 □No			
Division	fter fter oire n b	Certification:	4 Homicide determined		at nome, farm, streecify)	eet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled in	edical	29a. Certifier (Check only one) Certifying P 2 Medical Exa	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the tin restigation, in my o	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the h within 24 To the 3 complete	Σ	29b. Signature and title of certifier		10 0	29c. Licens		29d	Date signed (Month	h, Day, Year)
•	1		Int.	W/	1.0.		59552	0	1/22/20	005
0	2 '		30. Name and address of person who	co pleted cause of death (OLE RO	WESTM	INSTER I	MD 21157
.45.	Sta Reg <u>i</u> str	4	31. Date filed (Month, Day, Year) AUG 2 2 2005	32. Registrar's Si	gnature Local	e				

State Registrar Idsha

31. Date filed (Month, Day, Year)

ZGreenhe

2005

32.

111 Penn Street

Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physiciar /Medica Examine
Funeral

1 - For Stata Registrar

Director

permit. Pages 1 and 2 should be filed within 72 hours attar death with the Maryland Department of Health and Mental Hygiena. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, If a Modical Examiner roust be nutified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospitel or Attending Physicien: The law requires that the death certificate be exacuted within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

an	1. Decedent's Name	(First, Middle	A Last)	Toule	10			2. Date of Month	_ i [Pay	05 Year	3/time of peath 5
al er	4a. Facility Name (If	not institution	n, give street and nu	TOY C	<u>//\</u>	4b. City, Town, o	r Location of	HUGLA Death	-	4c. County	005 of Death	2113 AM
		are	Irving to	0		Beltim	ore			NIA		
	5. Social Security Nu 213 - 30 - 20 Usual Residence of D	623	6. Sex 1 M 2 ☐ F	7. Age (In yrs. I	ast birthday) X Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Month,		32	9. Birthp	place (State or Foreign htty) Y/ANA
tor	-	10b. County			Himo						1	0d. Inside City Limits
al Direc	10e. Street and Num		Ave.			10f. Zip Code	9			Citizen of W	Vhat Cour	ntry?
To Be Completed by Funeral Director	11. Marital Status 1 □ Never Marrie 3 □ Widowed	_	Armed F	2 No		Was Decedent of Hif Yes, specify Cuba	ispanic Origir In, Mexican, I Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-		k, White,	ean Indian, etc. CK
ompleted	(Specification)	y o <i>nly highe:</i> dary (0-12)	t's Education st grade completed) College (1-4or 5+)	(Give	dent's Usuat Occup kind of work done DO NOT use retired	durina most o	d working	16b.	Kind of Bu	siness/Ind	dustry
To Be Co	17. Father's Name (F						A A	Name (First, Midd	Me, Maide		e)	
	Paul Per	rerson	hip (Type, Print)		IN	Unite Ro	And Number of	or Rural Route Num DVEYNO F	ober, City	nor Town,	State, Zip	Code) 46
	` 4 □ Donation	Cremation		State C6	ace of Dispo emetery, crer	sition (Name of matory or other place CEME LE	e) 8.	Date -22-05	11.	Location - C Inclai		
	21. Signature of hi	11/1	low		G	Name and Addre	arch	Funeral Pass B	Has	nep A		129
	23a. Party. Enter the shock, or heart Immediate Cause (F disease or bondition resulting in death)	inal	a. PS	each line.	MOM		NOS	ocom NEUM	AL	10	5	Approximate Interval Between Onset and Death
amlner	Sequentially list conditions, reading to armicause. Enter Underly Cause (Disease or in that initiated events	ying jury	c	(or as a consequ			r	14 00(11)	014	· P·		
an/Medical Examiner	resulting in death) La	ist	Due to	(or as a consequ	ence of);							
75	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 9 Unknown	nonths?	1 Live t	tcome of pregnar birth 2 Fetal pant at time of de	death 3	Ectopic pregnancy Other (specify)				23d. Date Mon		ry Day Year
Completed by Physic	Part II. Other signific	ant condition		eath but not resu		nderlying cause give	on in Part I.		tobacco		bute to th	e cause of death?
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o Be	25. Was case referred examiner?		Hospital		R/Outpatien	Other	26. Place of	Death (Check only	one)			
catlon:	27. Manner of Death 1 Natural 2 Accident	5 Pending	ation	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work M 1 []		28d. Describe				
Medical Certification: T	3 Suicide 4 Homicide	6 Could r determi	ned 286. Place buildi	ng, etc. (Specify)		eet, factory, office		City or To	own, Sta	te)		Route Number,
edical	one)		g Physician: To the Examiner: On the b and man	best of my know asis of examinati her stated.	rledge, death on and/or inv	occurred at the timestigation, in my op	e, date and p inion, death o	place, and due to the occurred at the time	e cause(: e, date ar	s) and man nd place, ar	ner as sta nd due to	ated. the cause(s)
2	29b. Signature and tit	tle of certifier	lera	if wo)	29c. License	number 362		_	ate signed		Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

AUG 2 2 2005

Ave, Suite 308. Balto. Maz 1229

who completed cause of death (Item 23a) (Type, Print)

7NG MD · 3455, Wilkens

3455,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedeat's Name (First, Middle, Last) 2. Date of Death **Physician** Month ernon 0040A M /Medical 05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Wicomico Coastal Hospice at the Lake If Under 1 Year | Londer 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Days Months Hours Yrs. Director 509-22-2966 July 6, 1926 Kansas Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-f shov other traumatic evant. It a Micigal Examinar must be notified at Completed by Funeral Director 1 ☐ Yes 2☐ No Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11634 Dennis Drive 21853 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates: 153-55 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 composer/musician enteretainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be t of Health and Mental If itam 27 Is marked o Louis David Tompkins Nette Maude Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coastal Hospice at the Lake Deers Head Road Salisbury, MD 21802 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or once. `4 ☑Donation 5 ☐ Other (Specify) 21. Sign vary of Fun ral S ryice Lic Ronald S. ∭ade, State Anatomy Board 655 W. Baltimore Street mari 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** de disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 ☐ Yes 20 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes s after dea... ral Diractor: After ... by the funeral dir 27. Manner of Death 28a. ate of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha 26278 30. Name and address of person who completed cause death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

DAMOCOUAL MD 31. Date filed (Month, Day, Year)

AUG 2 2 2005

32. Megistrar's Signature

		1 - StatAmend Item# 5 Registrar	F		itilicate (or Death		Reg. No. 🛴 🔱	00 6141
ysici	an	1. Decedent's Name (First, Middle, La.	st)				2. Date of Dea		3. Time of Death
Medic		Austin Cru		.ng	T 2 =		August		
amin	er	4a. Fecility Name (If not institution, give				vn, or Location of De	ath	4c. County	100
		Anne Arundel Med 5. Social Security Number		(In yrs. last birthday	+	polis ear If Under 24 H		th	Arundel 9. Birthpleca (State or Foreign
eral ctor			⊠ M 2□F	Yrs.	Months Da	ays Hours Mi		y, Year)	Country) Maryland
		Usual Residence of Decedent					nuy. 1	27 2003	riarytano
3		10a. State 10b. County		10c. City, Town or L	ocation.				10d. Inside City Limit
the Medical Examiner must be notified at	Director	Maryland Anne A	Arundel	Odento	n				1 □Yes 2 🔀 N
9	Dire	10e. Street and Number			10f. Zip Co	de		10g. Citizen of W	/hat Country?
Trans.		611 Riden Stree	7		2111			U.S.A.	
ME	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent If Yes, specify (of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		- American Indian, k, White, etc.
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or other traumatic event,		20a. Method of Disposition	30	20b. Place of Disp cemetery, cre	osition (Name o	of place)	Date	20c. Location - 0	City or Town, State
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any injury or once.	l	21. Signature of Funeral Service Licer	nsee	2	22. Name and A	ddress of Facility	Dunama 1 ff		
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			negistrar Necedent's Name (First, Middle, Las	t)			imoati	0 01 2	Joann		2. Date of Dea	-	100	3. Time of Death
	Physici		Marjorie B.	Whitting	ton						Month Aug.	Day 22	Year 2005	5:25 A M
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	Funeral		5. Social Security Number 6. Se	7. A	ge (In yrs. last bii	thday)		1 Year	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)		place (State or Foreign ntry)
н	Director		212 20 6160	☐ M 2 🖾 F	85	Yrs.	Wilding	Days	110013		Oct. 17	, 192	21 M	aryland
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow	n or Lo	cation							10d. Inside City Limits
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and		Be c	Anthony J. Buck	,					10. 14/0(116			Andre		
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Ę	Page ent c nt: If ry or		1 ☐ Burial 2 ☑ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify							v 8/	23/2005		Winfi	eld, MD
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			23a, art1 Enter the disease, or comp	olications that cause	d the death. Do	not enti	er the mod	e of dying	g, such as	cardiac c	or respiratory arr	est,		Approximate Interval Between
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	xecut and II-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence	of):								
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ord	w requir been s should	ted	war repr	emen	; W1	7	_				1 🗆 Y	s 2	lo 3 Prob	ably 4 Unknown
Records,	e law r has be	Completed	0 ,								24a. Was a		4b. Were auto	psy findings available mpletion of cause of
	Th ate pag	Co									perform 1 ☐ Yes	ned?	death? 1 ☐ Yes	2 No
Vital	certifical rector, p	Be	25. Was case referred to medical examiner?	Hospital:				0**-		of Death	(Check only or	e)		
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Division	Attending r death. sctor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	jury - At home, fa	rm, stre			05 201		28f. Location (Si	reet and N	umber or Rura	l Route Number,
οį	를 를 를	Certification:	4 Homicide	building, e	tc. (Specify)		,	, 0.1100			City or Town			
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	n 24 he Fu	Medical	(Check only 2 Medical Exam	iner On the basis of and manner si	of examination an ated.	d/or ip	estigation,	in my op	inion, deat	h occurre	ed at the time, d	ate and pla	ice, and due to	the cause(s)
	To the P within 24 To the F complete	Σ	29b. Signature and title of certifier		//		29c	. License	number		2	9d. Date s	igned (Month,	Day, Year)
	/			1	6		0	37	مرس	C		Aus	224	d 200x
	5		30. Name and address of person who c	ompleted cause of	death (Ite (23a)	(Туре, І	Print)					4) "	A 0 0
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			05 tas	
Physician /Medical Examiner		cedent's Name (First, Middle, Last) Accility Name (If not institution, give street and number) 4b. City, Town, or Lo	S AUGUS	
Funeral Director	5. So	1-62-8143 10 M 201 37 Yrs. Months Days H	Hinder 24 Hrs. 9 Date of	Birth Day, Year) 9. Birthplace (State or Fore. Country) 7. 1968 Many and
or 28a-f show	10a.	Residence of Decedent State 10b. County 10c. City, Town or Location NA 10c. City Town or Location	moil	10d. Inside City Limi
uter deeth with the Mar r tems 23a or 28a-1 et niner must be notifiled Funeral Director	10e.	380 n, Calhoun A. 101. Zip Code 2	-1217	10g. Citizen of What Country?
ours after deeth w al', or Items 23a Examiner must. I by Funeral I	11. N	Never Married 2 Married 1 Yes 2 No	anic Origin? (Specify Yes or Mexican, Puerto Rican, etc.) Specify:	No- 14. Race - American Indian, Black, White, etc. Specify:
ed within 72 hours after deeth with the Maryland ygiene. The natural, or items 23a or 28a-1 show it, the Madical Examinat must be notified at Completed by Funeral Director		15. Decedent's Education (Specify only highest grade completed) mentary/Secondary (0-12) College (1-4or 5+) The control of the control of	on ing most of working	16b. Kind of Business/Industry Restarants
2 should be filed within and Mental Hygiene. le marked other then eumatic event, the Mental Comp	17. F	ather's Name (First, Middle, Last) Den (amin Chapman 18	8. Mother's Name (First, Middle)	Williams
permit. Pages 1 and 2 should be filed within 72 ho Depertment of Health and Mental Hygiene. Important: If Item 27 Ie marked other then "natur eny Injury or other treumatic event, the Madical once. To Be Completed	20a.	Method of Disposition Serial 2 Cremation 3 Removal from State Donation 5 Dentoer (Specify) Tiny (Specify)	ato a it bate Date 8-23-05	nber, City or Town, State, Zip Code) Outomar 21223 20c. Location - City or Town, State
permit. Deperti Import eny laj once.		Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	cron Pass	Parto mdi 21229 y arrest, Approximate Interval Between
The price of the p	Sequil and caus Caus that resu	a. Narcotic Intoxication (Metha Due to (or as a consequence of): b. Lieutially list conditions, y, leading to inneutiate e. Enter Underlying se (Disease or injury initiated events lting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	adone)	
nding Physician: The law requires thet the death certifical ath. 7: After this certificate has been signed by the attending phile funeral director, page 2 should be detached for use as the attent. 4 To Be Completed by Physician/Mediation:	IF F 23b	Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
quires thet the signed by uld be detacted by Physical British	Part	II. Other significant conditions contributing to death but not resulting in the underlying cause given		id tobacco use contribute to the cause of death ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unkno
The law requir cete has been si page 2 should Completed			, pe	As an attopsy prior to completion of cause death? 124b. Were autopsy findings available prior to completion of cause death? 124b. Were autopsy findings available prior to completion of cause death?
rs after death. all Director: After this certified in by the funeral director Certification; To Be		Description Property Proper	4 Nursing Home 5 H	esidence 6 XOther (Specify) SCENE be how injury occurred unk
# 8 8 F		Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, Iarm, street, Iactory, office building, etc. (Specify) Scene	Balti	n (Street and 1979) or Fire SSC man or Town, State) 1929 or Fire SSC man or more, Md
urs after ural Direction by Hed in by		 Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, 		
the Hospital or # iin 24 hours after the Funeral Dire- spletely filled in by ledical Certif	29a	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.		
To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should Medical Certification; To Be Completed	29a	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated. Signature and title of certifier 29c. License n		29d. Date signed (Month, Day, Year) AUGUST 12,2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 Len 20a per 1h, g846 8-22-05 vt

			State of Maryland / Dep 1- State of Maryland / Dep	artment of Health and Nartificate of Death			
	_		Hegistrar 1. Decedent's Name (First, Middle, Last)	Tuncate of Death	Reg. 2. Date of Death	<u>n</u> 2 U U 5	3. Time of Seator
	Physici		Rebecca D. Webster		Chiant	18 accs	837 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	-acyas, -	4c. County of Death	004 71
	LAGITIII	(F)	2015 Telegraph Road	Pylesville		Harford	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Rirth	place (State or Foreign
	Director		215–68–0840 1 M 2X F 41 Yrs.	Months Days Hours Min.	(Month, Day, Ye May 28. 1		ryland
	pu .		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Li	agation		VEE 2	
	larylan show	ħ					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	he M	Director	MD Harford Pylesvil 10e. Street and Number		140		
	with a or		2015 Telegraph Road	10f. Zip Code 21132	10g.	Citizen of What Coul USA	ntry?
	leath ns 23	Funeral		Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	can Indian
(0	riter o	듄	Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
5-0036	el', o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2√ No Specify:		Specify:	White
5-0	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23a or 28a-f show ont, the Medical Erer in et must be ricillised at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation skind of work done during most of work	ing 16b	. Kind of Business/In	dustry
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1/2 2	led w lygier lyer th		12	Food Service		Giant Foo	od
a Well	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. item 27 Is marked other then "naturel", or items 23a or 28a-f shot other traumatic event, the Medical Erac in at must be redilled at	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
્કે દું	should be nd Mental marked c	ို	Luchin E. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ing Address (Street and Number or Rur	. Shekerj		0.43
ß å E	nd 2 salth an 27 ls i			Telegraph Road, F			32
	ges 1 and 2 t of Health If item 27 or other tra		20a. Method of Disposition 20b. Place of Dispo	osition (Name of		. Location - City or To	
Aleca Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot		Location 3 □Removal from State cemetery, cre '4 □Donandon 5X Other (Specify entombrent Bel Air M	matory`or other place)	3/2005	Pal Ain	Manuland
	nit. F artme orten injur			2. Name and Address of Facility RL		Bel Air,	Maryianu Home Toc
ä	Dep Imp any			050 York Road, Tow			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	· · · · · · · · · · · · · · · · · · ·			Approximate
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	Examiner		Sequentially list conditions b				
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ta	icien: Th	ø	25. Was case referred to medical	26 Place of Deat	1 Yes 20	No 1 Yes	2 <mark>X</mark> No
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Division of Vital Records,	ding Phys h. After this funeral di	n: T	27. Manner of Death 1 □ Natural 5 □ Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year)		28d. Describe how in		,
<u>Ö</u> .	uttendir death. ctor: Af y the fu	ertification:	2 Accident investigation ALC 18 205 832	A M 1 ☐ Yes 2 No	Self-in	Photel	
: <u>≅</u>	r Att ter de irectu	rtific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	281. Location (Street City or Town, St	and Number or Rura	l Route Number,
Ω	oltal c	O	at hon		Telegraph 1	ld lylenole	Md 21132
	Hosp 24 hol Fune tely fi	dical	29a. Certifier (Check only (Check only 2 Medicel Examiner: On the basis of examination and/or in	h occurred at the time, date and place, westigation, in my opinion, death occurr	and dug to the cause ed at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Month,	
	FIFE		A colled on have	DAN / 1/ 00	1 1	# 10	7 3 000
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) -	6 Ull	gin 19,	105
U	1		BERMARD J. YUKM, WD, DIE 2018 HO	MBIRD AVE BAL	TRING	71275	
	Sta	te	31. Date filed (Month, Day, Year) 32. Agistrar's Signature	1. 0.	10 110	XI T X X	
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			1 - For State Registrar		State	of Maryla		artment of rtificate of				giene Rag. No. 0	05	274	21
	Physici	20	1. Decedent's Name (First, I	liddle, La	ist)				_		2. Date of Dea Month	ith Day	Year	3. Time of	Death
	/Medic		Diana				11iams				August		005	9:31	A M
	Examin	er	4a. Facility Name (If not insti			ımber)		4b. City, Town,					nty of Death		
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	288-1	rect	10e. Street and Number	TIOT	u		Lorest	10f. Zip Code				10g. Citizen	of What Cou		-X-,
	3e or	ΙDΙ	605 Bernade	tte	Drive			21050	ŀ			US		y.	
	deat	Funeral Director	11. Marital Status		12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of If Yes, specify Cu		igin? (Spe	city Yes or No-	14. F	ace - Ameri		
36	or Ite	by Fu	1 Never Married 2		1 ∐Yes If Yes, G	2 DNo ive		1 ☐ Yes 2 ☐ X No			ticari, etc.)	Spe	lack, White,		
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Baltimore,	permit. Pages. Department of the Importent: If ite any injury or of once.		21. Signature of Fure 15	vice cer	nse	/	22	. Name and Addi	ess of Facili	ty		1	חבת ער	rk Ros	ard .
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Ŋ,			23a. Part1. Enter the diseas shock, or heart failure.	e, of com List only	one cause on	caused the dea each line.	ath. Do not ent	er the mode of dy	ing, such as	cardiac or	r respiratory arr	est,		Approximate Interval Bety	ween
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	To the Hospitel or within 24 hours after to the Funerel Dirt completely filled in I	Medicai	(Check only 2 Med one)	ical Exar	ninar: On the b	asis of examin	ation and/or in	estigation, in my	opinion, dea	th occurre	d at the time, d	ate and place	, and due to	the cause(s)	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Augus ? 8 2005 20 John Winkel, Jr. Ernest /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL SAINT BACTIMOIZE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director 215-90-6959 41 April 3, 1964 Maryland Usuat Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "naturel", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at Maryland Baltimore Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5014 Leeds Avenue 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. should be filed within 72 hours after nd Mental Hygiene. marked other than "nature!", or Ite 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver UPS permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Importent: If itsm 27 is marked other you or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest Winkel, Sr. Mary Lorraine Sichelstiel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Winkel (Wife) 5014 Leeds Avenue, Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Baltimore Crematory @ 8/25/ 05 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 Fines the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between 2 Oncet and Death Immediate Cause (Final disease or condition PHELLMONIA Physician BIL MEQUE resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 12 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier
(chack only one)

29b. Signature and title of certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Laminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 600 60105 August 20 2005 completed cause of death (Item 23a) (Type, Print) 500 coton Avenue Brettmare MD 21775 HZRSOTE 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** BERNARD , WEST Tuly 3:35 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Blue Point Nursing Home Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Months Director 226-34-4944 75 May 26, 1930 North Carolina Usual Residence of Decedent with the Maryland 10a State 10c. City. Town or Location 10b County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1. Yes 2 No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23a 2525 W. Belvedere Avenue 21215 death v USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? U.S. Armed Forces? U.S. Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. unk Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or iter 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: black Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 home improvement 6 painter unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2627 W. Coldspring Lane Baltimore, MD 21215 Barbara Smith/niece 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department o Important: ff any injury or once. '4 □Donation 5 ☑Other (Specify) in state 21. Signatur: Funeral Service License State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic prostate concel /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. the 9☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) No 24a Was an certificate has 1 ☐ Yes 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Jursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 | atural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be determited 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by hours after 4 Homicide within 24 hours a pellij 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D00 57 465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Main Street, Suite 200, Reiskerstown, MD 21136 N.S. Rajapaksenio 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State Registrar 2 2005

		•	For State Registrar	State of Ma	ryland / Dep	artment of F	Health and N	lental Hyg	000	200
	Physici /Medio Examin	al	Decedent's Name (First, Middle, VER NON Aa. Facility Name (If nqt institution, see the see that the	WINDESHE give street and number)	111		or Location of Death	2. Date of Dea Month	Day Yeal 4c. County of De	3 020 1 W
	Funeral Director			7.0	(In yrs. last birthday 92 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day SEPT . 29	9. B 9, 1912	N/A irthplace (State or Foreign Country) MD
	th the Maryland or 28a-f ehow	Director	10a. State 10b. County MD BA	ALTIMORE	10c. City, Town or L	ONS VILLE 10f. Zip Code		1	10g. Citizen of What (10d. Inside City Limits 1 ☐ Yes 2 ☐ No Country?
920	72 hours after death with the Maryland naturel; or tems 23a or 28a-f ehow ited Exsciliet must be multied at	by Funeral	719 MAIDEN CHO 11. Marital Status 1 Never Married 2 Marrie 3 X Widowed 4 Divorced	12. Was Decedent E Armed Forces?		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🎇 No	21228 dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
121215-0036	d within giene. r than "	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	grade completed) College (1-4or 5+	(Give	edent's Usual Occup e kind of work done DO NOT use retire ESMAN	during most of work			s/Industry
Maryland	e d la la la la la la la la la la la la la	To Be	ABRAHAM 19a. Informant's Name/Relationship			DESHEIM	LILLIAN		r, City or Town, State,	AARON Zin Code)
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Balti	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Service Li	1	2	2. Name and Addre	ess of Facility SO	LLEVINS	ON & BROS	., INC.
68760,	/Medical Examiner physician and physician ships in the prival-fransit physician ships in the prival physician ships in the physician ships in th	icai Examiner	23a. Part1. Enter the disease, or coshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	э.	0.00	ng, such as cardiac	1 '	est,	Approximate Interval Between Onset and Death
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	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical Example 1 Medical Example 29b. Signature and title of certifier	Physicien: To the best of ceminer: On the basis of and manner stat	examination and/or in	nvestigation, in my c	opinion, death occur	red at the time, d	ause(s) and manner a late and place, and du 29d. Date signed (Mor	ue to the cause(s)
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	Sta	te	BLAHM 31. Date filed (Month, Day, Year)	SIGNAUOLS		Virid 21	e			
	Registr		AUG 2 2 2	32. Registra	Is figur	ske)				

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	Dhysia		1. Decedent's Name (First, Middle, La							2. Date of De	ath	Vana	3. Time of Death
	Physic /Medi		Wayne V. Young							Aŭgus	t 14,	2005 ^{ar}	7:10 Р м
	Examir	ner	4a. Fecility Name (If not institution, given Johns Hopkins			Ва	1tim				4c. C	ounty of Deat	h
511	Funeral Director		216-94-4819	Sex 7. Age (In	yrs. last birthday) 26 Yrs.	If Under Months		If Under a	24 Hrs. Min.	8. Date of Bir (Month, Da 8 - 23 -	th -78	9. Birt	hplace (Stete or Foreign untry)
7	anyiand show		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation							10d. Inside City Limits
	Mary Fresh	ģ	MD		Balti	nore							X□Yes 2□No
	h the	lrec	10e. Street and Number			10f. Zip	Code				10g. Citize	n of What Co	untry?
	23a c	alD	1215 N. Patters	son Park Av	ve.		212	13			USA		
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparantent of Health and Mental Hyglene. Importants if item 27 is marked other than "naturel", or items 23a or 28e-f show with fujury or other treumatic event, tra Medical Exa. Altar trivial be nutillised at once.	Funeral Director	11. Marital Status 1 ☐ Never Married 2 🔀 Married	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	cify Yes or No Rican, etc.)	1	Black, White	e, etc.
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Baltimore, Maryland 21215-0036	ges 1 t of H If ite or otl		20a. Method of Disposition 1 Burial 2X Cremation 3	Removal from State	Ob. Place of Dispo cemetery, cren	sition (Nam natory or of	ne of ther place)		ate		tion - City or 1	
Ë	it. Pa rtmen rtant; njury		4 ☐ Donation 5 ☐ Other (Specification of Jun al Service Licer		Bayview							lalk,M	
Ba	Depa Impo eny ir	li li	> Wesley	house	20	007 E	East	ern	Ave	ley Ch . Balt	o. M	Jr. D 212	FH 312
	Physician /Medical		23a. Part1. Enter the disease of com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Contact G	unshot W				cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner			Due to (or as a co	nsequence of):								
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Courte (or as a con									
8760,	cate be executed physicien and the burial-transit	dical E		Due to (or as a con	rsequence or):								
.O. Box 6	Attending Physician: The law requires that the death certific roteath. ctor: Atter this certificate has been signed by the ettending py the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 □	Ectopic pre					230	d. Date of delive Month	very Day Year
Division of Vital Records, P.O.	juires that n signed b	þ	Part II. Other significant conditions of	ontributing to death but no	t resulting in the ur	nderlying ca	iuse giver	in Part I.			obacco use		the cause of death?
00	s been si	olete								24a. Was	an 2	24b. Were aut	opsy findings available
al Re	n: The lav ficate has or, page 2	Completed	25. Was case referred to medical							autop v perfo	sy	prior to co death?	ompletion of cause of
₹	ysician: is certifica director, p	To Be	examiner?	Hospital:	2 ER/Outpatien	2000	Othor			Check only o			
0	g Phy er this	핕	27. Manner of Death	28a. Date of Injury	28b. Time of		n	THE INDIS		ne 5 Resid			fy)
<u>.</u>	tending F death. tor: After the funer	atlo	1 □Natural 5 □ Pending 2 □ Accident investigation	Found 05	tr) Injury	м	Work?	s 2 X N	lo	Subject	Shot	Self	
Divis	9 4 4 5	Certification:	3X Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp. Scene	At home, farm, stre	eet, factory,	office			8f. Location (S City or Tow ark, Ba			Patterson
	Hospi 4 hou Funer tely fill	edlcal C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my liner: On the basis of exar and manner stated.	knowledge, death mination and/or inv	occurred a estigation,	it the time	, date and nion, death	nlace a	nd due to the	221160/6/ 25	d manner en	stated
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/		29c.	License	number			29d. Date s	igned (Month,	Day, Year)
			Vanute Fresh	rell, MID		0.	.С.М.	Ε.		A	ugust	16, 2	005
			30. Name and address of person who	completed cause of death		Print)							_
				thall mo		enn St	reet	, Bal	ltimo	ore, Ma	rylan	d 212	01
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 2 200	32. Registrar's S	ignature for	W							

Barraclough, Naomi Baltimore, Marvland 21215-0036

68760,
Box
P.O.
Records
Vital
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ion

State of Maryland / Department of Health and	
1- State Registrar Certificate of Death	Reg. 2005 27426
1. Decedent's Name (First, Middle, Last) Physician Maomi Marie Barraclough	2. Date of Death Month Day Yeer August 8 2005 7:30a M
4a. Facility Name (If not institution, give street and number) Berlin Nursing & Rehabilitation Ctr. 4b. City, Town, or Location of Dea	ath 4c. County of Death Worcester
Funeral Director 5. Social Security Number 153-20-0592 6. Sex 1 March	rs. 8. Date of Birth 9. Birthplace (State or Foreign
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
MD Worcester Berlin 106. Street and Number 107. Zip Code	1)∰Yes 2□No
106. Street and Number 401 Broad Street 21811	10g. Citizen of What Country? USA
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married	
3 X Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation	16h Kind of Rusiness/Industry
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done	orking
Elementary/Secondary (0-12) College (1-4or 5+) Secretary 17. Father's Name (First, Middle, Last) Henry Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or First)	Tire Business ame (First, Middle, Maiden Surname)
Henry Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fi	
등 등 등 등 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fi 모듈	Rural Route Number, City or Town, State, Zip Code)
20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
Siloam Cemetery 08/1 21. Sign ≥ 76 June 2 Service Licensee	1/2005 Vineland, NJ urbage Funeral Home
22. Name and Address of Facility BU 108 William Street	Berlin, MD 21811
23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart ailure. List only one cause of enter the mode of dying, such as cardia limediate Cause (Final disease or condition resulting in death)	ac or respiratory arrest, Approximate Interval Between Onset and Death Cut 4
Examiner Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Used or a space of that initiated events c.	
f any, leading to immediate cause. Enter Underlying Cause Discourse (Discourse of Stat	
physicia the buy	
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the undestying cause given in Part I. INSULU DEPUTE AND DEPUTE AND AND AND AND AND AND AND AND AND AND	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown
	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? Hospital:	eath (Check only one)
1 Yes 2 Ne Nospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Jursing I 27. Manner of Death 28a. Date of Injury 28b. Time of Injury Work?	Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28a. Place of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury 28c. Injury at Work? 28c. Injury 28c. Injury at Work? 28c. Injury 28c. Inju	296 Leasting (Street and Alumbar of Durch David Number
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work?	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one)	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier 29c. License number	29d. Date signed (Monith, Day, Year)
30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) 15 10 10 10 10 10 10 10 10 10	etal Hohum De 190111
State Registrar AUG 1 0 2005 32. egistrar's Signature	Jung Villary

•			For State Registrar		State of M	aryland		rtment tificate			and M	-	giene Reg. No	000	07107
			1. Decedent's Name (i	First, Middle, Lasi)							2. Date of De	ath	- 4 4 6	3: Time of Death
	Physici /Medio		MARGARET	FRANCE	S BELL							Month	Da		
).	Examir		4a. Facility Name (If no	ot institution, give	street and number	-)		4b. City, T	own, or	Location of		J		. County of Dea	
			Manokin Ma		sing Home	:		Prin		Anne	_		So	merset	
	Funeral		5. Social Security Num	4.5	x 7.A □M 2 X F	ge (In yrs. Ia	,,	If Under 1 Months	Year Days	If Under :	24 Hrs. Min.	8. Date of Bir (Month, Da 4/11/1	th y, Year)	0	rthplace (State or Foreign ountry)
	Director		233-34-963 Usual Residence of De				85 Yrs.					4/11/1	920	We	st´Virginia
	yland			0b. County		10c. City,	, Town or Lo	cation							10d. Inside City Limits
	Mar •-f sl	ctor	MD	Somerset		Prin	ncess	Anne							1X Yes 2 ☐ No
	or 28	Director	10e. Street and Number					10f. Zip 0	Code				10g. Cit	izen of What C	ountry?
	ath w	rai	11974 Edg	ehill Te				218	53					USA	
	er de Items	Funeral	11. Marital Status		12. Was Deceden Armed Forces	?		Vas Decede Yes, specif	ent of His fy Cubar	panic Orig n, Mexican	gin? (Spe Puerto I	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh	
36	irs aft	by F	1 ☐ Never Married 3X Widowed 4 [1 Tes 2 15 If Yes, Give Year or Dates:		1	☐ Yes 2	X No	Specify:				Specify: TAT	hite
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23e or 28e-f show avant, the Medical Exam har must be multiply at	ted		5. Decedent's Edu	ucation		16a. Deced	ent's Usual	Occupa	tion			16b. K	ind of Business	
21	thin 7 e. an "n	Completed	(Specify Elementary/Seconda	only highest grad ary (0-12)	le <i>completed)</i> College (1-4or	5+)	(Give . life. L	kind of work OO NOT use	done di retired)	uring most	of workir	ng			
21	filed withl Hygiene. other than ant, the M	Con	12				Homema	ker					Don	nestic	
nd	be fill htal H d oth	Be	17. Father's Name (Fir									(First, Middle,	Maiden	Surname)	
Maryland	d 2 should be th and Mental ?7 is marked o traumatic ava	P	19a. Informant's Name	INKNOWN)	and Defeat		405 14 11		1		VKIVOV				
Ma	d 2 s h an 7 is trau		George A.											r Town, State,	zip Code) s Anne, MD
ē	s 1 and 2 f Health item 27 i		20a. Method of Dispos		,	20b. Pla	ace of Dispos	ition (Name	g of	1		ate	20c. Lo	cation - City or	Town, State
E S	Pages nent of int: If it ury or o		1 ☐ Burial 2 X 0	Cremation 3 ☐F	Removal from State		^{metery, crem} isbury	•		· 1	2/11/	2005			, Maryland
altimore,	permit. Pages 1 Department of H Important: If itel any injury or ott	li	21. Signature of Funer			Dull						eral H			Maryrand
m	90 5 6 9		Much	ODS	Lan		1	O3 Li	ay M nden	ersor Ave.	i Fur Po	eraı н сотоке	ome, Cit	P.A. y, MD 2	21851
			23a. Part1. Enter the shock, or heart fa	disease, or compl ailure. List only o	lications that cause ne cause on each	d the death.								7,	Approximate Interval Between
1	Priysician		Immediate Cause (Findisease or condition	nal	9	cerel	brova:	cular	, 0	curo	unt				Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as				, 0,						
		L .	Sequentially list condit	tions,	b	2 222222	ASOVI)							5 years
-	nsit	nine	Sequentially list condition any, leading to immediate (Disease or injury)	ng Iry	Due to (or as	s a conseque	ence or).								
Ć,	execu n and ial-tra	Examine	that initiated events resulting in death) Las		Due to (or as	s a conseque	ence of):								
8760,	cate be executed physician and the burial-transit	ō			d										
9	ntifica ng ph as th	Medic	IE EENALE	-											
Вох	death certifica e attending pt id for use as t	an/I	IF FEMALE: 23b. Was decedent pro- in the past 12 mo	agriant	3c. If yes, outcome 1 ☐ Live birth			Ectopic preg	ananev				- 1:	23d. Date of de	
0.	ne des the al	hysician/Me	1 Yes 2 N		4□Pregnant a 9□Unknown	t time of dea		Other (spec						Month	Day Year
Δ.	that the deby the detached	Δ.	Part II. Other significa	nt conditions co	ntributing to death !	hut not result	ting in the un	derlying car	ISA TIVAT	in Part !		23a Did to	bacco u	ee contributo t	o the cause of death?
Records,	es us	d by	•				ang m ano an	sorry mg out	,50 giva:	11111 (411)			es 2	,	robably 4 DUnknown
202	> 1 0	lete						.				24a. Was		Oth Wass a	tana findana a alabia
Re	The taw ate has b page 2 st	ompieted										autop perfo	sy med?	prior to death?	utopsy findings available completion of cause of
Vital	i cien : Th certificate rector, pag	o .	25. Was case referred	to medical						26 Place	of Death	1 ☐ Yes (Check only o		1 U Yes	2 No
of V	di is	To B	examiner? 1 ☐ Yes 2 ☑ No	H	fospital: 1 🗌 Inpati	ent 2□E	R/Outpatient	3□ DOA	Othor					6 □Other (Spe	cify)
0 0			27. Manner of Death 1 ☑Natural 5	5 □ Pending	28a. Date of inju (Month, Da	ury 2 ay Year) 2	28b. Time of Injury	280	. Injury a			8d. Describe h			
Sio	tan leath tor: the	cati	2 Accident	investigation				М		es 2 🗆 N					
Division	i te	Certification:	4 Homicide	determined	28e. Place of In building, e	jury - At hom tc. <i>(Specify)</i>	ne, farm, stre	et, factory, o	office		2	Bf. Location (S City or Tow	itreet and m, State,	d Number or Ri	ural Route Number,
	Hospital		29a. Certifier 1 ₽	Certifying Phys	sician: To the best	of my knowi	ledge death	occurred at	the time	data and	place o	ad due to the			
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 one)	Medical Exami	ner: On the basis of and manner st	ot examinatio	on and/or invi	estigation, in	n my opii	nion, death	occurre	d at the time,	date and	place, and due	to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title					29c. l	License	number			29d. Date	e signed (Mont	h, Day, Year)
			> me No	who were				D	05/	359			Aug	gust 10	Th 2005
	. 1		30. Name and a firess						777				-		
<u>,</u>	TII		DR. USHA	NATESA	N. 14	15.5	·DIVIS	ION	37	SA	LISB	ury	70	21804	
	Sta Registra	te ar	31. Date filed (Month	UG'1"0 20	005 32. Figist	ars Signatu	DIVIS	and,						,	
					7-0-0										

			ror	partment of Health and Mertificate of Death	Re	9. No. 005 27428
	Physici /Medio		1. Decedent's Name <i>(First, Middle, Last)</i> Ola Alderman Bolt		2. Date of Death Month August	Day Year 745 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) Solomons Nursing Center	4b. City, Town, or Location of Death Solomons		4c. County of Death Calvert
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ▼ F 7. Age (In yrs. last birthda yrs. last birthda yrs. last birthda yrs.	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, May 27	
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Calvert 10c. City, Town or Hunt:	ocation ingtown		10d. Inside City Limits 1 ☐ Yes 2 🖔 No
	3a or 28a	Funeral Director	10e. Street and Number 3620 Hnting Creek Road	10f. Zip Code 20639		og. Citizen of What Country? United States
980	72 hours after death with the Maryland Instural', or items 23s or 28s-1 show dical Exactiner must be notified at	þ	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	- 200	Completed	(Specify only highest grade completed) (Git Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired) naker	ing	6b. Kind of Business/Industry own home
Maryland	S should be filed withlr and Mental Hygiene. Is marked other than aumatic event, Ire M.	To Be	17. Father's Name (First, Middle, Last) James Madison Alderman	18. Mother's Name	e (First, Middle, M cy Addie	
	and 2 sho ealth and I n 27 is mu			ling Address (Street and Number or Rura Hunting Creek Rd.		
Baltimore,	Page nent o int: If iry or		1 № Burial 2 □ Cremation 3 □ Hemoval from State 4 □ Donation 5 □ Other (Specify) Harris (ematory or other place) Cemetery Aug 10	2005 W:	illis VA
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Raus 405 Broomes Is. Rd.	sch Fune: Port Re	ral Home epublic Maryland 20676
8760,	Physician and // // // // // // // // // // // // //	Ilcai Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Rospirale	ry F	and leve Onset and Death Cool
P.O. Box 6	The law requires that the death certificate be executed ate been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	uires that n signed bi	d by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1	acco use contribute to the cause of death? s 2 No 3 Probably 4 Unknown
I Records,	: The law requir cate has been si , page 2 should	Completed by	Seck Sines Syran	<u> </u>	24a. Was ar autopsy perform 1 Yes 2	prior to completion of cause of
of Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		
	ling After funa	ation: To	1 Yes No 105 1 Inpatient 2 ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time Injury 2 Accident Investigation 2 Accident 2 Acciden	of 28c. Injury at	28d. Describe ho	nce 6 □Other (<i>Specify</i>) w injury occurred
Division	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	treet, factory, office	28f. Location (Str. City or Town	eet and Number or Rural Route Number, State)
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) **Gertifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ith occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the ca red at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier A Theory Thypus	29c. License number 9 4 2 7	7	nd. Date signed (Month, Day, Year) Sugust 8 2005
	2		30. Name and address of person who completed cause of death (Item 23a) (Type A. Munshi, MD Hospital Drive Pa		vland 20	0678
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registry's Signature			

			For State Registrar	State of Marylar		artment of H			giene	271.20
			1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea	The last to the la	3. Time of Death
ı	Physici		Kathryn Ann Bu	ılach				Month August	3, Day 2005 Year	9:45 P M
	/Medic Examir		4a. Facility Name (If not institution, gir			4h City Town o	or Location of Deat		4c. County of Dea	
	LAdiiii	ie.	Shady Grove Adve			Rockvi		•		
	Funeral			Sex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgom	
	Director			1 □ M 2 🛣 F 52	Yrs.	Months Days	Hours Min.	(Month, Day		thplace (State or Foreign buntry)
	D		Usual Residence of Decedent					riag. 2,	1933 Wasi	illigeon, be
	ylany		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mar	호	Maryland Montgo	omery	Germant	.own				1 ☐ Yes 2X No
	r 28g	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	h with	0	13403 Demetrias	Wav		20874			USA	18
	deat me 2	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13. V		dispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Race - Ame	erican Indian,
9	after or ita		1 ☐ Never Married 25 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		_		o Rican, etc.)		
ဓ္ဓ	ral', c	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I□Yes 2☑No	Specify:		Specify: Wh:	ite
2	within 72 hours after death with the Maryland ene. then "natural", or itams 23s or 28a-f show he Madical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	ient's Usual Occup	pation	4.:	16b. Kind of Business	/Industry
2	thin .	d d	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	life. L	OO NOT use retired	during most of word)	king	Giant Food	9
2	od wi	ő	10		Del	i Counte	r Worker		Grocery St	core
5	al Hy al Hy oth vent	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
<u>a</u>	uld b Ment wrkac write a	2	Kenneth A. Steir	hoff			Peggy A	A. White		
ar	s ma	·	19a. Informant's Name/Relationship (** *					r, City or Town, State, a	
Σ	and and all all ar tra		John M. Bulach/	Husband	134	03 Demet	rias Way,	, German	town, MD 20	0874
more, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic svent, the Madical Examiner must be notified at once.		20a. Method of Disposition		lace of Disposementery, crem	sition (Name of natory or other place	ce) l	Date	20c. Location - City or	Town, State
Ĕ	Pag if and and and and and and and and and and		1 ☐ Burial 2 【※Cremation 3 ☐ 3 ☐ Contact Specific Speci	Indilioval light State		tan Crem	· 1	August 5	Alexandria	.Virginia
Balti	mit.		21. Signature of Funeral Service Lice		-		-		Home Inc	·, · · · · · · · · · · · · · · · · · ·
ñ	Per limit on y		medici	we ttelke	50	ancis J. O Univer	sity Blvd	runeral 1. W. Sil	Home Inc Lver Sprinc	, MD 20901
			23a. Part1. Enter the disease, or com	plications that caused the deatl						Approximate
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.					. •	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Pulmonary Fi						1 Year
	Examiner			Due to (or as a conseq	uence or):					
		ē	Sequentially list conditions,	b	sence off-					
	ted nsit	in in	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	,						
	xecu and al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence)	uence of):					
8/60	cate be executed bhysician and the burial-transit				,					
98	icate phys	dicai		d						
	death certificate attending place as t	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	ncv			11-11		
X P P	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d. Date of del	very Day Year
o.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	eath 5	Other (specify)				,
J.	requires that the een signed by th nould be detache		Part II. Other significent conditions of	contributing to death but not resu	Ilting in the un	derlying cause gry	en in Part I	23e Did tob	pacco use contribute to	the sauce of death?
Š	signe signe d be	l by	Pseudomonas Pneu		aung in me un	derlying cause givi	en mrann.			
Cord	w require been sign should b	Completed						1 L YE	es 2 No 3 Pr	opably 4 XiUnknown
d)	s law	npidu						24a. Was ar autops	v prior to d	topsy findings available completion of cause of
	The law cate has page 2:	Co						perform 1 ☐ Yes 2	ned? death?	
VITA	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					th (Check only on		
5	d is	္ရ	1 ☐ Yes 2X No	Hospital: 1X Inpatient 2	ER/Outpatient	3□ DOA Oth	er: 4 Nursing Ho	ome 5 Reside	nce 6 Other (Spec	nity)
	ding Ph th. After th funeral	on:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at c?		w injury occurred	
DIVISION	r Attending or death.	ati	2 Accident investigation		. ,		Yes 2□No			
Ë	al or Attend after death Director: / d in by the f	ertificati	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Str. City or Town	reet and Number or Ru	ral Route Number,
	spital or Atten ours after deat teral Director: filled in by the	O I			,			ony or roun	, 01010/	
	e Hospital of 24 hours at e Funeral Distely filled it	edicai	29a. Certifier 1 Certifying Ph	ysician: To the best of my know	viedge, death	occurred at the tim	ne, date and place,	and due to the ca	use(s) and manner as	stated.
	To the Hox within 24 h To the Fur completely	edi	one)	niner: On the basis of examinat and manner stated.	ion and/or invi	estigation, in my op	oinion, death occur	red at the time, da	ate and place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of pertifier	/ , ,		29c. License	number	29	od. Date signed (Month	, Day, Year)
	a		Carlell Ac	pelle.	MA	D26	5540		August	4, 2005
	O		30. Name and address of person who	completed cause of death (Item	23a) (Type, F	Print)			J	
			Carl I. Schoenbe				Road, Ga	ithersbu	rg, MD 208	77
	Sta	_	31. Date filed (Month, Day, Yeer)	32. Registrar's Signat	ure	artes				
	Registra		AUG 0.8	71111h	M M	M34/1/				

			1 - State of Maryl Registrar		artment of F			giene	271.30
			Decedent's Name (First, Middle, Last)				2. Date of De	ath	3. Time of Death
	Physici /Medic		Raymond Wilbur Buck Jr.				Aug.	Day Year 3. 2005	8:04 P ^M
	Examin		4a. Facility Name (If not institution, give street and number)		_	r Locetion of Dea	th	4c. County of Dea	ath
			Washington Adventist Hos		Takoma			Montg	
	Funeral		1MM 20 F	yrs. last birthday) C Yrs.	If Under 1 Year Months Days	Hours Min	. (Month, Da		rthplace (State or Foreign ountry)
	Director		217-30-0096 8	66 Yrs.			Apr. 2	20,1919 M	aine
	yland 10w		10a. State 10b. County 10c	. City, Town or Lo				-	10d. Inside City Limits
	Mariati	ctor	Maryland Prince George's		College P	ark			1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code	- U		10g. Citizen of What C	ountry?
	ath w	rai	4902 Laguna Road			0740		USA	
	er de	Funerai	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puei	Specify Yes or No rto Rican, etc.)	14. Race - Am Black, Wh	
36	irs aft	by F	1 Tangle 1 Tangle 2 Married 1 Tangle 2 No If Yes, Give 3 Widowed 4 Divorced 1 Tangle 1 Tangl	/II	1 ☐ Yes 2 🙀 No	Specify:		Specify: W	hite
Š	d within 72 hours after death with the Maryland Jiene. I than "natural", or Items 23a or 28a-f show The Medical Examinat must be notified at		15. Decedent's Education	16a. Dece	dent's Usual Occup			16b. Kind of Busines	s/Industry
215	within 7 ene. than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired	d) most of we	Jikilig	Montgomer	v
21	filed with Hygiene. other than	Con	12 5+	P	rofessor	40.44.1.4.1.	(PT) . A 41 . II	Community	
and	be fill	Be	17. Father's Name (First, Middle, Last)					, Maiden Sumame)	
₹	houtd d Mer marke	٦ ر	Raymond Wilbur Buck 19a. Informant's Name/Relationship (Type, Print)	19h Maili	ng Address (Street			ean Hare or, City or Town, State,	Zin Code)
Maryland 21215-0036	es 1 and 2 should be filed of Health and Mental Hygi If item 27 is marked other or other traumatic event, I		Carol L. Davis, Niece		-			•	Maine 04017
ē,	t Head item			b. Place of Dispo	osition (Name of matory or other place	ne)	Date	20c. Location - City o	r Town, State
E O	Page nt. o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	•	an Crematory		4, 2005	Alexandria	, Virginia
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or of		21. Signature ol Funeral Jery ce Licelle e	2:	2. Name and Addre	ss of Facility			
<u> </u>	89 = 89		Ken K. I women					al Home, P ltsville, I	
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e th. Do not en	er the mode of dyin	ng, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Pnysician	1	Immediate Cause (Final disease or condition resulting in death)	MM	vma				
	/Medical Examiner		Due to (or as a con	is unc of):	nvin				
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a con	sequence of):	VAG			<u> </u>	1
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diesace of kilmy that initiated events	1'					
o,	sician and burial-transit		resulting in death) Last Due to (or as a con	isequence of):					
8760	P & B	edicai	d						
9	leath certifica attending ph for use as t		IF FEMALE: 23c. If yes, outcome of pre						
Вох	ath cattend	ian/	in the past 12 months?	Fetal déath 3[☐Ectopic pregnancy ☐ Other (specify)	/		23d. Date of de Month	Day Year
o.		Physician/M	1 Yes 2 No 9 Unknown	ordeam St	Other (specify)				
۹.	res that the signed by th be detache		Part II. Other significant conditions contributing to dealer ut not	t resulting in the t	erlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
Vital Records,	= 0,0	ed by	- Chienic Ammy	elly 1	wemm	ary all	Var 10	Yes 2 ☐ No 3 ☐ F	robably 4 Unknown
000	law requas been 2 should	plet	- Mulial (Oli	10 Carry			24a. Was		utopsy findings available completion of cause of
R	9 4 9	Completed	75-55-51	/			perfo	ormed? death?	
ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?			26. Place of De	ath (Check only o	one)	
of	d is	Ţ	A	2 ER/Outpatier		4 Nulsing I		dence 6 Other (Spe	ecify)
n (ion	27. Manner of Death 1 ☐ Matural 5 ☐ Pending (Month, Day Yea) 2 ☐ Accident investigation	ar) 28b. Time o	Wor	yat k? Yes 2∐No	26d. Describe	how injury occurred	
Division		ertification;	3 Suicide 6 Could not be 28e. Place of Injury	At home, larm, st				Street and Number or F	Pural Route Number,
Ω	al or A after I Direct	erti	4 Homicide determined building, etc. (Sp	recify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, State)	
	o the Hospital or At vithin 24 hours after of the Funeral Direct ompletely filled in by	caiC	29a. Certifier 1 ☐ Certifying Physician: To the best of my (Check only 2 ☐ Medicel Examiner: On the basis of exar	knowledge, deat	th occurred at the tir	me, date and plac	e, and due to the	cause(s) and manner a	s stated.
	To the H within 24 To the F complete	Medicai	one) and manner stated.				arroa ar trio timo,		
	To Too	Σ	29b. Signature and title of certifier		29c. Licens	111 -	7	29d. Date signed (Mon	Lay, real)
,	15		20 Name and address of parties who are a lead a support	(Itam 22a) /Tim-	Drint\	0/7/	/	0/5/0	0-0.5
			30. Name and address of person who completed cause of death of the second secon			11 A.z	TAL	ema Park	20912
	Sta	ite	31. Date filed (Month, Day, Year) 32. pegistrar's S	ignature	CARRO	11 /100	- ITA	VALL VIEW	(
	Registr	ar	AUG 0 5 2005	N. A.	BALL				

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Herbert A. Buxbaum 2, 2005 10:34 P.M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 6509 Old Stage Road Rockville If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 → M 2 □ F Director 201-03-7322 84 December 20, 1920 Pensylvania Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or Items 23a or 28a-f ahow 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State s 23s or 28s-f show Rockville 1 XYes 2 No Maryland Montgomery **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6509 Old Stage Road 20852 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or Items any finity or other traumatic event. It a Medical Enamine Inspire. 11. Marital Status 1 TXYes 2 □ No If Yes, Give Year or Date-WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Executive Jewelry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental H ant: If item 27 Is marked ot Borden Buxbaum Hortense В. Herbert A. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James C. Buxbaum/ Son 8632 Garfield Street, Bethesda, MD 20817 20b. Place of Disposition (Name of commetery, crematory or other place)
Geo. Wash. University August 3
Medical Center 2005 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4X Donation 5 ☐ Other (Specify) 2005 Washington, D.C. 22. Name and Address of Facilit Columbia Mortuary Services, Inc. 21. Signature of Juneral Service Licensee P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PI) LMONARY Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) _ 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2/2NNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Sesidence 6 □Other (Specify) this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? e Hospital or Attending P 24 hours after death. e Funeral Director: After ti 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No M 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a tix Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title completed cause of death (Item 23a) (Type, Print) 30. Name and address CONNECTICUT AVE KENSINGTON MD 20895 10810 EDSTEIN MCK Registrar's Signature 31. Date filed (Month, Day, Year) State 05 2005 AUG Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 2005 10:10A ELIGIUS BOVELLO August 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Spa Creek Nursing Home Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1X M 2 TF Yrs. Director 578.05.6793 95 1909 Washington, DC Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County ir than "natural", or itame 23a or 28a-1 show the Medical Examinar must be notified at 1X Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 318 Legato Terrace it. Pages 1 and 2 should be filed within 72 hours after death virtnent of Health and Mental Hygiene.
ritent: if item 27 is marked other than "natural", or tame 23st hirry or other traumatic event, it wheretal Examiner in Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) Printer U.S. Government 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Be Guiseppe R. Bovello Emilia Bovello 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dolores F. Wilson/Daughter 318 Legato Terrace, Silver Spring, Maryland 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Loudon Park Crematory 8/11/2005 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC.
11800 New Hampshire Ave, Silver Spring, MD 20904 21. Signature of Funeral Service Licer any in Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final Pnysician agestue disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed nding physicien and use as the burial-transli Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient Other: 2 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. 28d. Describe how injury occurred injury at Work? Certification: After 1 Natural 2 Accident 5 Pending death. 1 Yes 2 No investigation hours after death uneral Director: A 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Fo the ... within 24 hours ... - the Funeral D' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) title of certifier 29b. Signature D57028 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Auc #231 Annapolis, mo 21401 31. Date filed (Month, Day, Year) 32, Registrar's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per Dr., G846, U8/22/00dhb.

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month Robert Bryan Bridges /Medical 08 09 2005 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lions Manor Nursing Home Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Oct 11, Funeral Birthplace (State or Foreign Country) 1 € M 2 □ F Yrs. Director 220-16-6818 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Neuferd Examinar must be notified at MD Allegany Cumberland Be Completed by Funeral Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 West Offutt Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ita Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 ₭ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) truck driver Finkle Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert B. Bridges, Sr. Thelma L. Atkinson Bridges Beal ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Luikart daughter Rt 4 Box 90 WV 26753 Ridgeley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. injury or St. Luke's Cemetery 8/13/2005 Cumberland * 4 ☐ Donation — 5 ☐ Other (Specify) MD 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licens 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Uremia Immediate Cause (Final disease or condition resulting in death) Physician 6 months /Medical Due to (or as a cons - uence of): **Examiner** End State Renal Failure Sequentially list conditions, Tary, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 6 months Examiner Due to (or as a nonsequence or) as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 200 No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No Other: 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident investigation 1 ☐ Yes 2 ☐ No in by the Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funeral I 1/Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) woulde 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Terrace Frostburg MD

DHMH 17 Rev 1/2001

State Registrar

WONSOCK SHIN

31. Date filed (Month, Day, Year) AUG 2 2 2005

48 Taron

MD

32. Registrar's Signature

			State of Maryland / Department of Health and M	lental Hyg	iene	27434
			For State Registrar AMEND TTEM #23PTT PER PHY COSTITION OF THE AITH AND THE PHY COSTITION OF THE AITH AND THE PHY COSTITION OF THE AITH AND THE PHY COSTITION OF THE AITH AND THE PHY COSTITION OF THE AITH AND THE PHY COST	2. Date of Deat		3. Time of Death
П	Physici		Geraldine S. Coughenour	Month August	Day 2005	450 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deatl	
			St. Vincent de Paul Nursing Home Frostburg 5 Social Security Number 6 Sax 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	9 Date of Righ	Allegany	
Н	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min.	8. Date of Birth (Month, Day,		nplace (State or Foreign untry)
			Usual Residence of Decedent	110-1-15		and leader Ob. Liebs
	show	5	10a. State 10b. County 10c. City, Town or Location Frostburg			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M	Director	10e. Street and Number 10f. Zip Code	11	Og. Citizen of What Co	untry?
	h with 23a or at be		48 Tarn Terrace 21532		USA	
	within 72 hours after death with the Maryland ane . than "natural", or liems 23a or 28a-f show tha Maulcal Examitier i wat be motified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spr. If Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates:		Specify: Wh	ite
21215-0036	2 hou	ted	15. Decedent's Education 16a, Decedent's Usual Occupation	ina	16b. Kind of Business/I	
21	ithin 7 ne. han r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	9	Home	
d 21	be filed with ital Hygiene. id other than event, the N		12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M		
lan	d a b	To Be	Millard Melvin Smith Grace V	iola Clo	uson	
Maryland	bra E E		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			
	s 1 and 2 of Health i item 27 i		Billie E. Smith, Sr., brother 12138 Cash Valley Roa 20a. Method of Disposition (Name of		umberland, 20c. Location - City or	
Baltimore,	of of		cemetery, crematory or other place)		Hyndman, F	
altin	permit. Pag Department Important: I any injury o		21. Signature of Fineral Service Lichosau 22. Name and Address of Facility			
ñ	9 F P 8		Harvey H. Zeigler F			ian, PA
П			23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac canock, or heart failure. List only the cause on each line.	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Gause (Final disease or condition resulting in death) Choule Obstitutive	hing	Disease	5 years
	Examiner		Due to (or as a consequence of):			Ü
	в =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of);			
760,	sician buria	calE				
89	tificate ig phys as the	ledic				
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	very Day Year
о. В	the the	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			
Δ.	that the ned by detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	equires an sign	ed by	Deft Hip Fracture	1 □ Ye	s 22No 3 Pro	obably 4 □Unknown
of Vital Records,	e law requ has been je 2 shoul	Completed	Dialettes	24a. Was ai autops	y prior to d	topsy findings available ompletion of cause of
E R	The f cate ha page	Con		perform 1 ☐ Yes 2	ned? death? No 1 ☐ Yes	2 No
Vita	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No		e) Ince 6 □Other (Spec	(6.1
of	g Phya er this ieral di		27. Manney of Death 28a. Date of Injury 28b. Time of 28c. Injury at		w injury occurred	ay)
ion	Attending F death. ctor: After y the funer	atio	2 Accident investigation M 1 Yes 2 No			
Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,			
	To the Ho within 24 h To the Fu completely	edical	(Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.			
	Vith To t	Σ	29b. Signature and title of certifier ## Clustary D 588 5 3		9d. Date signed (Month	, Day, Year)
				1		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HABIB CHOTANI, 13i PENNSYLVANIA AVE,	Cum	BERLAND), MD 21502
	Sta		31. Date filed (Month, Day, Year) AUG 2 2 2005			
	Registi	rar	AUG 2 2 2000 Places St My			

		•	1 - For State Registrar	State of Maryland		rtment of H			ene g. No. 200	5 27435
			Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
	Physicia		Rose Gyurko Cseplo					Month August	Day Yeer 5 2005	7:00 a M
}	/Medic Examin		4e. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death		4c. County of Dee	
	CAGIIIII	CI	Manor Care - Bethe	sda		Bethesd	а		Montgome	ry
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9 Ri	thplece (State or Foreign ountry)
	Director		227-80-8252	M 21√2 F 83	Yrs.	Months Days	Hours Min.	Mar. 6,		ngary
			Usual Residence of Decedent							T
	how		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	e-f-e	cto	Maryland Montgome	ry Be	etheso	la				
	h th	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	15 wi		6216 Rockhurst Roa	d		208			USA	
	dea me	Funeral	11. Marital Status	2, Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
0	or It		1 Never Married 2 Married	1 □ Yes 2 🛣 No If Yes, Give		☐Yes 2☑No	Specify:		Specify:	
<u> </u>	ours	d by	3 Widowed 4 □ Divorced	Year or Dates:						White
က်	72 h "natu	Completed	15. Decedent's Educa (Specify only highest grade		16a. Deced (Give	lent's Usual Occupa kind of work done of	ation du <i>ring</i> most of work f)		16b. Kind of Business	s/industry
2	Athin ne. han	ш	Elementary/Secondary (0-12)	College (1-4or 5+)			,		O-m II-m o	
2	be filed within 72 hours after death with the Maryland and Hygiene. d other than "natural", or teme 23a or 28e-f ehow do other than "natural", or teme 23a or 28e-f ehow event, the Medical Examinar must be notified at		17. Father's Name (First, Middle, Last)	1	Homema	iker	18. Mother's Nam	e (First, Middle, N	Own Home	
E C	~ - 0 =	Be								
3	2 should be filed v n and Mental Hygie te marked other t raumatic event, Ib	ို	John Gyurko	o Print)	19h Mailir	na Address (Street	Elizabe		1 rko City or Town, State,	Zin Code)
ā	2 st and r		19a. Informant's Name/Relationship (Type	-						
ຜົ	l and lealth om 27 ther t		Margaret L. Schrib 20a. Method of Disposition	20h Pla	ce of Disno	Rockhurs			a, Marylan	
Ö	Peges nent of the ant: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State Fair	netery, crer rfax 1	natory or other place demorial	:0)		,	
Itimore, Maryland 21215-0036	tent tank		'4 □Donation 5 □Other (Specify)			Park Name and Addres	Aug. 8	3,2005 I	Burke, Vir	ginia
Bal	permit. Peges 1 and 2 should be Department of Health and Menia Importent: If Item 27 Is marked any injury or other traumatic evonce.		21. Signature of uneral Service Licenses	Co. 1	F1	cancis J.	Collins	Funeral	Home, Inc	•
	40 5 8 Q		23a. Part Enter the disease, or complice	ceres	5(00 Univer	sity Blvc	l.,W.,Sil	Lver Sprin	o MD 20901 Approximate
			shock, or hear failure. List only one	e cause on each line.	Do not ent	er the mode of dylin	ig, such as cardiac	or respiratory arre	,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a.	Bilateral Pne	eumon:	ia				
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					
	Cxammer		Sequentially list conditions, b.	Urosepsis Due to (or as a conseque						
-	si ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
	and and -trans	Саш	that initiated events c. resulting in death) Last	Hypercalcemia Due to (or as a conseque	ance of):				·	
Ö,	ate be executed hysician and the burial-transit	<u> </u>			31.00 017.					
	ate the	dical	d.	Dementia						
9	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as:	Physician/Med	IF FEMALE: 23	3c. If yes, outcome of pregnan	cv				23d. Date of de	alivan
Вох	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetel of 4 Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)	1		Month Month	Day Year
o -	the a	ysic	1 Yes 2 No	9☐ Unknown	atti J					
٥.	that the	P.	Part II. Other significant conditions conf	tributing to death but not result	ting in the u	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
JS,	signe signe	d by						1 □ Y€	s 2□No 3□F	Probably 4 Munknown
O.	v requir been s should	Completed						24a. Was a	24b Ware	autopsy findings available
ec	has t	ldu						autops	y prior to	completion of cause of
=		S								s 2 No
/its	ysicien: The is certificate ha director, page	Be	25. Was case referred to medical examiner?	ospital:		Oth		th (Check only on		
of Vital Records,	Physicien: this certific ral director,	P	T Tes 2 PNO	I L Inpatient 2 L E	R/Outpatier 28b. Time o	IL 3LI DOA	41- Nursing H		ence 6 Other (Sp ow injury occurred	ecify)
Ë		ertification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2 □ No	200. 0000.100 1.0	w injury social of	
Division	Attending r death. sctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hon	ne farm st		100 20.10	28f Location (St	reet and Number or F	Rural Route Number.
Ξ	in He	iti	4 ☐ Homicide determined	building, etc. (Specify)	no, rain, sc	oot, ractory, onloo		City or Town		
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	O	29a. Certifier 1 🔼 Certifying Phys	sician: To the best of my know	riedge deat	h occurred at the til	me, date and place	and due to the ca	ause(s) and manner :	as stated.
	24 hc Fun stely	edical	(Check only 2 Medical Exemin	ter: On the basis of examination and manner stated.	on and/or in	vestigation, in my o	ppinion, death occur	rred at the time, d	ate and place, and di	ue to the cause(s)
	ithin o the omple	Me	29b. Signature and title of certifier	. 1		29c. Licens	se number	2	9d. Date signed (Mor	nth, Dey, Year)
	H 3 F 8		Deeti 1/	ohre M.	0	D 20	1277		\u0010+ 5 ?	005
•	3		30. Name and address of person who con	moleted cause of death (Item	23a) (Tvna	Print) D 20	12/4		August 5,2	.005
			Kirti Vohra, M.D.	7710 Bradle			Sethesda N	MD 2081	7	
	C+	ate	31. Date filed (Month, Day, Year)						·	
	Regist		AUG 08 20	32 Aegistrar's Signat	T. A	Sec.				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time di Dentin 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Ruth Ann Calderon 2005 August 3, 8:32 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) NOV. 12, 1961 If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Hours Months Days 43 212-86-8977 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic evant, It a Madical Examinar must be notified at 1 ☐ Yes 21 No Maryland Montgomery Silver Spring Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 2714 Sheraton Street 20906 **IISA** death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Berniece Johnson Chester Dove ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Deportment of Health and Important: If itam 27 is m any injury or other traum Berniece Dove/Mother 2714 Sheraton Street, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State August 6, Parklawn Memorial Park Rockville, Maryland 4 □ Donation 5 □ Other (Specify) **2005** 21. Signature of Puneral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or comprior tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only in cause on each line. Approximate Interval Between Onset and Death RESPIRTURY PAILURE Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner SMILL CELL LUNG CHICCR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner PUMONARY physician and the burial-transit ABROSIS The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medicai d attending ph IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ANEUMONIA, HEMOPYSLO 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has autopsy 2 No 1 Yes To the Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: P 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date f Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. М 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a
To the Funeral C
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 036252 NGUST 03, 2005 10 bleted cause of death (Item 23a) (Type, Print) HE #575, WHOTON MD 20902 30 Name and add (MI) Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

				1 - For State of N		Depa		lealth and M Death	•	2005	27437
				Decedent's Name (First, Middle, Last)	-				2. Date of Death		3. Time of Death
		Physici /Medic		Charles Edwin Carney					Month August 2	Day Year . 2005	1:10 a M
		Examin		4a. Facility Name (If not institution, give street and number	er)		4b. City, Town, or	Location of Death	<u> </u>	4c. County of Deat	
				Suburban Hospital			Betheso			Montgom	
		Funeral		1 X 7 N 20 C	Age (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birt	hplace (State or Foreign ountry)
		Director	ļ	577-42-5117 Usual Residence of Decedent	73	Yrs.			Feb. 28,		shington, DC
		land II		10a. State 10b. County	10c. City, Tov	wn or Loc	ation				10d. Inside City Limits
		death with the Maryland ms 23e or 28e-f show	tor	Maryland Montgomery	Whea	aton					1 ☐ Yes 2 🙀 No
		r 28a	irec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
		th wit	aiD	11930 Andrew Court			20902			USA	
		ams ams	by Funeral Director	11. Marital Status 12. Was Decede Armed Force		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
	36	or It	y F.	1 Never Married 2 Married 11€ Yes, Give		1	☐Yes 2X No			Specify: Whi	
	Ö	hour turat	q pa	3 ₩idowed 4 Divorced Year or Date 15. Decedent's Education	s: 1952–56	1	ent's Usual Occupa	ation	166	. Kind of Business/	
	15	in 72 n "na	Completed	(Specify only highest grade completed)		(Give k	rind of work done of NOT use retired	during most of workir)	ng	ontgomery	12_ 1
	212	yiene.	ШО	Elementary/Secondary (0-12) College (1-40		aperv	ising Di	spatcher		olice Dep	=
	þ	e filed at Hyg otha	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name			
	/lai	uld b Wentz wrked	To	Chester Wayne Carney				Mary Jo	sephine I	Hession	
	Maryland 21215-0036	2 sho and i is me		19a. Informant's Name/Relationship (Type, Print)			,	and Number or Rura			
	≥, ≥	s 1 and 2 should be filed within 72 hours atter death with the Marylar if Health and Mental Hygiene. item 27 is marked other then "naturet", or Items 23e or 28e-f show other traumetic event. Ite Medical Exertation is used the confilled at		Carolyn Carney Lanham/ Da							
	Baltimore,	permit. Pagas 1 and 2 should be filed within 72 hours atter death with 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat", or Items 23a or stay injury or other traumatic event. Its Madical Examination 181 but once.		20a. Method of Disposition 1			ition (Name of atory or other place	Augi	ust 5,	. Location - City or	
	ţ	ritmen ritmen ritmen njury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Gate or		en Cemeter				ng,Maryland
	Bai	perm Depa Impo any i		21. Signature of Futheral Service Licenses		Fr	ancis J.	collins	Funeral F	Home Inc	
				23a. 2nt1. Enter the disease, or complications that cause	sed the death. Do					er Sprin	g, MD 20901 Approximate Interval Between
		Dhusisian		shock, or heart failure. List only one cause on each Immediate Cause (Final					, ,		Onset and Death
, 🛡		Physician /Medical		disease or condition resulting in death) Pneumo	as a consequence	of):					1 Week
2 5		Examiner									
ر ت		n =	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	as a consequence	∋ of):					
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5	50,	oe axi	Ē	Due to (or	as a consequence	9 Of):				I	
5 8	68760	cate I physi the b	dicai	d							
00	ox 6	certifi iding ise as	/We	IF FEMALE: 23c. If yes, outcor	ne of pregnancy					23d. Date of deli	1001
	Bo	death certificate e attanding phys ed for use as the	Physician/Med	in the past 12 months?	2 Fetal death		Ectopic pregnancy Other (specify)			Month Month	Day Year
	0	that the d ad by the detached	hysi	9 Unknown	1		, , , , , ,				
7	Is, P	uires that the dei signad by the a Id be detached t	by P	Part II. Other significant conditions contributing to death	a but not resulting	in the und	derlying cause give	en in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
U	rds	v requires been sign should be		Coronary Artery Disease	Conges	stive	Heart F	ailure,	1 ☐ Yes	2 X No 3 □ Pro	obably 4 DUnknown
>	900	aw 1st 2s	piet	Renal Failure					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
ARNE	Ä	The te h	Completed						performed 1 ☐ Yes 2 🔯	? death?	2□ No
5	Vital Record	rding Physician: Th th. : After this certiticate s tuneral director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Death			
	of V	Physician: r this certitic ral director,	2	1 ☐ Yes 2 ☐XNo Hospital: 1 🔀 Inpa	atient 2 ER/O		3□ DOA Othe	ar: 4 Nursing Hom			city)
S		ing P	inol.	27. Manner of Death 1 28 Natural 5 ☐ Pending (Month, I	njury 28b. Day Year)	Time of Injury	28c. Injury Work		8d. Describe how in	njury occurred	
37	Division	ttand death death tor: , the t	Certification:	2 Accident investigation 3 Suicide 6 Could not be	Injury - At home, fa	farm etra		Yes 2□No	8f. Location (Street	and Number or Bu	ral Route Number
B	Di√	lor A atter Direc	ertif	4 Homicide determined 286. Place of building,	etc. (Specify)	am, ste	et, ractory, office		City or Town, St	ate)	rar ribute reamber,
HARL		spita lours naral		29a. Certifier 1 Certifying Physicien: To the be	st of my knowledg	ge, death	occurred at the tim	e, date and place, a	nd due to the cause	e(s) and manner as	stated.
27		To the Hospital or Attanding within 24 hours atter death. To the Funaral Director: After completely tilled in by the fune	Medicai	(Check only 2 Medical Exeminer: On the basis one)	s of examination ar	nd/or inve	estigation, in my op	oinion, death occurre	d at the time, date	and place, and due	to the cause(s)
		To the within To the comp	W	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month	n, Day, Year)
		1.1		that MD			d60	117	7	uaust 2,	2005
_	17	H		30. Name and addre of person who completed cause of			*				
0.	10			Of Data Blad (Manth Day Vand)	-1			e, Rockvi	lle, MD 2	20850	
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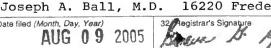
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 **Physician** Victoria Pastora Cuellar Chicas August 5, 9:35 p /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery General Hospital Olney If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 22, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 1 ☐ M 2 ☐ **S**F 77 1928 Honduras 578-74-5036 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Tyes 2X No Director Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number filed within 72 hours after death with 20832 Honduras 4613 Morningwood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 图 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1⊠Yes 2□ No Specify: Honduran SpecifyWhite Baltimore, Maryland 21215-0036 þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other transmits. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincenta Chicas Zuniga Jesus Cuellar Merino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4613 Morningwood Drive, Olney, MD 20832 Emiliana Lobos-Kirker/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory Dete 20c. Location - City or Town, State 20a. Method of Disposition August 9, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ruptured Abdominal Aortic Aneurysm disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by funeral director, page 2 should be Cardiomyopathy, Sepsis, Acute Renal Failure 1 Tes 2x No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 Yes 2 No 1 Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home Certification: To 1 ☐ Yes 2X No 1√ Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After 5 Pending 1 X Natural 1 Yes 2 No efter death. Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral C Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OSph A Bx D 2331

State Registrar

31. Date filed (Month, Day, Year) 2005 AUG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



16220 Frederick Road, #213, Gaithersburg, MD 20877

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	0		Registrar 1. Decedent's Name (First, Middle, Last)		imouto o	Dout		2. Date of Dea	ith		J	3. Time of De	eath
	Physicia		Willaco. T Cohen					Month 😿	Day		Year 05	1800	М
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town	, or Location of	(Death		4c.	County of			
			ALMC		tun	-porte	5		ANI	NE AF	RUND	EL	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	- 1	If Under 1 Yea Months Day			8. Date of Birth (Month, Day	Year)		Cour	lace (State or F	
	Director		5/8-46-5469	Yrs.				09/09/1	936	<i>h</i>	VASH	IŃGTON,	DC
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	wn or Lo	cation						1	0d. Inside City	Limits
	Mary f sho	ō	MARYLAND ANNE ARUNDEL ANNAPO)T TC								1∭Yes 2	□ No
	1 the	Director	10e. Street and Number	/113	10f. Zip Code	,		1	10g. Citi	izen of Wh	nat Cour	ntry?	
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	ems a	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of f Yes, specify Ci	f Hispanic Orig	gin? (Spe	cify Yes or No-		14. Race			
0	or it		1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 【 No If Yes. Give	}	1☐Yes 2XIN		,			Specify:			
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a Z	and N		19a. Informant's Name/Relationship (Type, Print) 19	b. Mailir	g Address (Stre	et and Numbe	r or Rural	Route Number	r, City o	r Town, S	tate, Zip	Code)	
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ore	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury propher traumatic events.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of cemeter	of Dispo ery, crer	sition (Name of natory or other p	lace)	Di	ate	20c. Lo	cation - C	ity or To	wn, State	
Ĕ	Pag ment ant: I		'4 □Donation 5 □Other (Specify) MT. L	EBAI	NON CEMI	ETERY 0	8/10	/2005	ADEI	LPHI,	MA1	RYLAND	
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	/Medical Examiner		Due to (or as a consequence	i 6f):	100							1	
		in the	Sequentially list conditions, if any, leading to immediate b. Due to (or as a const quence	e of):	1 912	عصمم					-	year	_
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Ω Q	tifical ng phy as th	ed								_			
X O D	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat	h 3[Ectopic pregnar	ncv			2	23d. Date		*	
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0	nding ith. :: Afte	atlor	1 Malatural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		ìork? □Yes 2□N	No						
Division	Atte	ifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	farm, str	eet, factory, offic	8	2	8f. Location (Si City or Town			or Rura	l Route Number	r,
2	tal or safte al Dir ed in	Certification:	building, etc. (Specify)					Ony or rown	ri, biaio,				
	tospi t hour	edical	29a. Certifier (Check only Medical Examiner: On the basis of examination a	je, death	occurred at the	time, date and	d place, a	nd due to the c	ause(s) late and	and mann	ner as st	ated.	
	To the Hospital or Attending Physical Carlot Attending Physical Public Attended to Tothe Funetal Director: Affer this completely filled in by the funeral directors and the funeral directors.	Medi	one) and manner stated.			nse number							
	P 3 2 8	-	29b. Signature and title of certifier				-	2		_		Day, Year)	
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	7		30. Name and address Herson who completed cause of death (Item 23a)			true	الم يوه	Ris 124	0	51	Ux	/	
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Phy		·	Registrar I. Decedent's Name (First, Middle, L.	ast)	06		Death	2. Date of Deat	ng. No. 15	3, time of Death
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Fune Direc			579-48-6964	Sex 7. Age	e (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rear) (rthplace (State or Foreign Country) ASH. D.C.
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h the	Director	3	Oe. Street and Number			10f. Zip Code		10	g. Citizen of What C	country?
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be filed within 72 hours after death with the Maryland latal Hygiene. It all Hygiene wood other then "nature!, or iteme 23e or 28e-f show event. It wedood to the marginal part of the marginal part o	hv Funerail	5	1. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 7 M If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (S n, Mexican, Puerl Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
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· # 5 =	3 0		F FEMALE:							3-5 DAYS
death certific e attencing p	vsician/A		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 **Physician** August 2, Jefferson Adam Dardin, Jr. 3:25 P. M /Medical 4c. County of Death 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital Calvert. Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **X**☐M 2☐F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 83 May 12, 1922 Arkanas Director 430-20-5232 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "neturel", or items 23s or 28s-f show the Medical Examiner must be nutified at 1 ☐ Yes 2X No Director Maryland | Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20678 260 Dresser Ave. United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Maritaf Status filed within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuaf Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Board of Education Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Public School Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leatha Tulliver Jefferson Adam Dardin, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JoAnn B. Dardin (Wife) 260 Dresser Ave., Prince Frederick, Maryland 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
eny injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesly Cemetery 8/05/05 Prince Frederick, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Rd., Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Doset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Zheima attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death signed by the at d be detached fo 5 Dther (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 PYes 2 □ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has t lirector, page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 • Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 2 R/Outpatient 3 DOA After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. fnjury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide within 24 hours after To the Funerel Dire to a cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatufe and title of certifier 17168 Drollmar Ce 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Kioumarce Yazdani, M.D. 2555 Solomons Island Rd., Huntingtown, Maryland 20639 31. Date filed (Month, Day, Year) 32. Registres Signature State **-** 5 2005 ▶ Registrar

DHMH 17 Rev 1/2001

1 - State Registrar Certificate of Death Reg. No 2005 4c. County of Death Prince Georges 8. Date of Birth (Month, Day, Year) April 17, 1918 Birthplace (State or Foreign Country) Virginia 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Refrigeration 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20706 20c. Location - City or Town, State Washington, D.C. 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 TYes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 281. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 8/03/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) reter · M Schisser MD 7500 6 7500 Greenway Ctr. Or. Greenbelt, MD 20770 Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per Verb., C84-page 19723/05dfb

Certificate of Death

Reg. No. 1 - For State Registrar Reg. Np. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:30 PM 8 2005 Frederick Lewis Edwards /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner 106 Edward Taylor Rd. Ocean City Worcester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**À**M 2□F Months Director 193-18-0505 82 10/6/1922 Nanty Glo, Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 27 is marked other than "naturel", or Items 23a or 28e-1 show treumatic event, the Medical Examinating the notified at 1 ☐ Yes 2X No Director Fairfax Springfield VA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Completed by Funeral 7231 Braddock Rd. 22151 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: 1942-45 Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) FBI 5+ Special Agent 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Fred Edwards Maude Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sment of Health an 7231Braddock Rd., Springfield, VA 22151 Norma Edwards (Wife) other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Surial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Quantico Natl. Cem. | 8/15/2005 Triangle, VA 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee a. Part1. Enter In disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only be cause on each line. 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death Immediate Cause (Final Physician En VENTRICULAR FIBRILLATION disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physicien: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) $\omega_{\rm O}/\ell$. $C_{\rm O}$, $\omega_{\rm C}/\ell$. Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CARDIAC DERHYMMIAS Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Street (Specify Yes 2 No Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Hospitel or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

23 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai completely To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 0 06241 8-9-05

State

DHMH 17 Rev 1/2001

Registrar

263 SNOW ST, SNOW HILL, MD. 21863

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 1 0 2005

32. Signature

DUR OTHY

31. Date filed (Month

			1 - For State Registrer	State of M	arylan	d / Depa		t of H	lealth a			_	15	27444
	0,		1. Decedent's Name (First, Middle, La	st)							2. Date of Deat			3. Time of Death
	Physici /Medic		Shirley Marie F	edenia							Month August	4, 2005	Year	1:10 a M
	Examin		4a. Facility Name (If not institution, giv	e street and number))		4b. City,	Town, or	Location of			4c. County		
			Shady Grove Adv	entist Hos	spita	1	Roc	kvil	10			Mont	aome	rv
	Funeral		Social Security Number 6. S	ex 7. Ag		last birthday)	If Under Months		If Under 2	24 Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign intry)
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	and *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation			-				10d. Inside City Limits
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Maryland	it. Pages 1 and 2 should be riment of Health and Ments reent: If item 27 Is marked njury or other treumatic e		19a. Informant's Name/Relationship (Route Number,			o Code)
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و	S T E		1 Burial 2 ☐ Cremation 3 ☐	Removal from State	a	e of He	natory or ot	ther plac		Aug	ust 8.	20c. Location -		
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9	g phy as th			7.										
Вох	death certifica attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			·					23d. Date	of deliv	ery
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P.O.	that the de led by the a detached t	hys	9 □ Unknown	9□ Unknown							1			
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Division	l or At after d Direct I in by	Certification:	4 Homicide determined	28e. Place of In building, et	ury - At ho c. (Specify	me, farm, stre	et, factory,	office .		28	If. Location (Str. City or Town,	eet and Numbe State)	r or Rura	al Route Number,
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•	16		30. Name and address of person who	completed cause of a	leath (Item	23a) /Temo	Print)		00/	16	1	10/	/	2)
			Dr. Bipder Sui	99011	Medi	lal 1	CPAN	ter	D	VIVE	ROCI	quelle	14	10 7.550
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State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yeer **Physician** Rert Fisk August 6, 2005 9:40 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Asbury-Solomons Health Care Center Calvert Solomons If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** 2 □ F Director 519-18-3681 95 Nov. 8, 1909 Idaho Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Calvert. Solomons 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11517 Emmanuel Way 20688 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1941-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Navy other than Elementary/Secondary (0-12) College (1-4or 5+) communications engineer research & development 5 perriit. Pages 1 and 2 should be file Deputrment of Health and Mental Hy, Important: if item 27 is marked othe any Injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dell Fisk Hulda Synder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Weeks Fisk, wife 11517 Emmanuel Way, Box 534, Solomons, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 08/08/05 Alexandria, VA 21 Signature of Funeral Service Licensee 22. Name and Address of Facility ilback Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NO VMLAID 2 Luch /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy 8 K--~1 2 No this certificate 1 Yes 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide fter within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 046314 30. Name and address of person who sumpleted sause of death (term 198) (Type, Print) Paul V. Pomilla, M.D., 110 Hospital Rd. #310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registral's Signature State AUG - 8 2005 ▶

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item #10b Per FH g848 90/12/8/19 of Peath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Irving Gertler 2:45 P 2005 /Medical Aug. 1 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens Silver Spring Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**⊠** M 2□ F Min. Months Days Hours Yrs. Director 577-22-1605 88 29, 1917 Jan. New York Usuel Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location in then "netural", or itams 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Montgomery 1 ☐ Yes 2 ☑ No Directo Maryland Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3142 Gracefield Road, #106 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 √ Yes 2 No If Yes, Give Baltimore. Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient important: If term 27 is marked other the any injury occurrent. Salesman Automotive injury or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Julius Gertler ం Rose Kalichstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul A. Gertler, Son 10217 Blandford Way, Ellicott City, Maryland 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) B'Nai Israel Cemetery Aug. 5, 2005 Oxon Hill, Maryland 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 21. Signature of Funda Service Consec 4400 Powder Mill Road, Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. shock or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Recurrent Cerebrovascular Accidents Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Carotid Stenosis Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit Atherosclerotic Cardiovascular Disease that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician P.O. Box 68760 requires that the death certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9□ Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à Ischemic Colitis Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2 **X**No 2 No 1 ☐ Yes 1 Tes Division of Vital To the Hospitei or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 5 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. i Director: A 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerei Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and ti rtifier 29c. License number 29d. Date signed (Month, Day, Year) D24035 Aug. 2, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Eugine Machado, 3110 Gracefield Rd., Silver Spring, MD 20904 31. Date filed (Month, Day, Year) State AUG 08 Registrar 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Lillian Goldstein 4:30 P M August 2005 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Sex 1 M 2 F 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Director Yrs 060-03-0327 86 Jan. 18, New York 1919 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturef, or Items 23e or 28a-1 show any injury or other treumetic event, Ite Modified Exampling to a new Item Item. 10d, Inside City Limits Director Maryland Montgomery Silver Spring 1 X Yes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 15107 Interlachen Drive, # 322 Funerai 20906 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☑ No 3 √ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Gerstein Molly Stettner ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara R. Cohen - Daughter 4832 Flower Valley Drive, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Mem. Gardens 8/5/2005 4 ☐ Donation 5 ☐ Other (Specify) Olney, Maryland 21. Signature of Funeral Service Licensee Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20852 porald 23a. Part 1. Enter the disease, or complications that caused the grath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Ventricular Tachycardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): Physician/Medicai the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death Day Year 5 Other (specify) the 9 Unknown 9 Unknown ρλ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Anemia Be Completed 1 Tes 2 No 3 Probably 4 Unknown GI Bleed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy performed? certificate 1 🗆 Yes 1 Yes 2X No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certification: To 1 ☐ Yes 2🛣 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

Box 68760. P.O. Division of Vital Records.

Baltimore, Maryland 21215-0036

Hospital or Attending Physicien: The law requires that the death certificate be executed filled in 24 hours a To the within 2

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31. Date filed (Month, Day, Year) AUG 08 Registrar

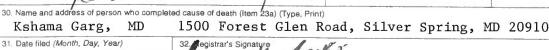
(Check only one)

29b. Signature and title of certifier

Kshama Garg,

shama

2005



29c. License number

D60826

29d. Date signed (Month, Day, Year)

August 3, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 02, 2005 August Doris Jean Garnett 5:45 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3700 Gallatin Street Prince George's Hvattsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea May 19, I **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🕱 F Days Hours Min 579.84.6605 48 Yrs. Director Augusta, GA Usual Residence of Decedent death with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or Items 23e or 28e-f shov the Medical Exemple: must be notified at 1 ☐ Yes 2 X No Director Maryland Prince George's Hyattsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3700 Gallatin Street 20782 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 Widowed 4 N Divorced Year or Dates Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) International Union of Brick Layers Allied Elementary/Secondary (0-12) College (1-4or 5+) 4 Assistant Director Craft Workers 7 Is marked other treumetic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fil if Health and Mental H itam 27 Is markad oth Leon Thomas Remel White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua M. Garrnett / Son 3700 Gallatin St. Hyattsville, Maryland 20782 itam 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ita
any injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 08/04/2005 Brentwood, Maryland ⁴ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or a rt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cluse (Final disease or condition resulting in death) Physician a Metastatic Pancreatic Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) any leading to lime di cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Exam Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 Pregnant at time of death Day 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ peq Breast Caner 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No 1 Yes 2 X No Physician: the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 2 Other: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After or Attanding 1 XNatural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 To the 29b. Signature and title of certified 29c. License number

D

Registrar

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Francine Higgs-Shipman, M.D., 11700 Beltsville, #100, Beltsville, Maryland 20705 31. Date filed (Month, Day, Year) 05 AUG 2005

30. Name and address of person who completed cause of deam (Item 23a) (Type, Print)

Registrar's Signature

are my

)Z80 79

29d. Date signed (Month, Day, Year)

P.O. Box 68760. Division of Vital Records, Physician; or Attending

Baltimore, Maryland 21215-0036

within 24 hours a To the Hospital

> Jonathan Matthew Wenk, 31. Date filed (Month, Day, Year) State AUG 09 2005 Registrar

29b. Signature and title of certifier

M.D. 9901 Medical Center Dr., Rockville, MD 20850 megistrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0005

29d. Date signed (Month, Day, Year)

NAME: HARDY, ALFRED H.

FLL. (0. $\pm 24q$ Division of Vital Records, P.O. Box 68760,

			State of Maryland / Der 1- State Amend Item 24a per Dr. C84/ AMEND ITEM #10a-f C486 8/31/6		
	Dhusia		Decedent's Name (First, Middle, Last)	2. Da	te of Death 3. Time of Death
	Physici /Medi		Alfred Henry Hardy		onth Day Year 19:43 A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Reeder Nursing Home	Boonsboro	Washington
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 232-/16-2817 12 M 2 F 77 Yrs.	Months Days Hours Min. (Mo	te of Birth 9. Birthplace (State or Foreign Country) 30, 1928 West Virginia
	Director		232-46-2817 1XPM 2CLF // Yrs.	May	30, 1928 West Virginia
	land wo		10a State 10b County 10c City Town or I	ocation	10d. Inside City Limits
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f ehow he Madical Examinar must be notified at	ţō	W Jefferson Maryland Washington Boonsbore	Ranson	1 ☐ Yes 2 反 No
	r 28a	by Funeral Director	10e. Street and Number 410 NORTH MARSHALL ST.	10f. Zip Code	10g. Citizen of What Country?
	3a ol		141 South Main Street	21713 25438	United States
	death ms 2	Jere	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Specify Ye	es or No- 14. Race - American Indian,
9	after or Ita	Ē	Armed Forces? 1 □ Never Married 2 □ Married 1 ☒ Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto Rican,	etc.) Black, White, etc.
21215-0036	ral',	l by	31 St Wildowed 4 □ Divorced 1950 − Year or Dates: 1953	1 ☐ Yes 2 ☒ No Specify:	Specify: White
5	72 h natu dical	Completed	15. Decedent's Education 16a. Dece	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business/Industry
2	vithin ne. han'	ldu	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	
7	ould be filed with Mental Hygiene. arkad othar thar atic evant, the M			urity Guard	Communications
ano	be fi	Be	17. Father's Name (First, Middle, Last)		Middle, Maiden Sumame)
<u> </u>	should ind Men marka umatic	P	Robert Hardy		unobtainable)
Maryland	12 sho h and 7 Is mu Iraum			Cartor Asso. HArnons E	
	1 and 2 Health tam 27		Sherry Lescalleet / Daughter 345 20a. Method of Disposition 20b. Place of Disp	Carter Ave. HArpers F	
٥	Pages nent of H int: If its		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, cre	August 1	1 , 20c. Location - City or Town, State
ţi	t. Partmer			nt Crematory 2005	Baltimore, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itams 23s or 28s-f show any Injury or other traumatic evant, the Madical Examinat must be notified at ance.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility esthaven Funeral Serv	ices, Skkot Cody P.A.
1	402 4 4		9	Jul Catoctin Mrn. Hwy	Frederick, MD 21/01
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List a fly one cause on each line.	iter the mode of dying, such as cardiac or respi	ratory arrest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Fina) disease or condition resulting in death)	ral failure	1 meet
	Examiner		Due to (or as a consequence of):		
١.		7.	Sequentially list conditions, ff any, leading to immediate Due to (or as a consequence of):		
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
	be executed sician and burial-transit	xar	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
760,	te be ex tysician ne burial	cal			
687	ficate physis the		G		
Box (The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
m	atte for	ciai	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	Month Day Year
P.O.	the c	hysi	9 Unknown 9 Unknown		
	w requires that s been signed b should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given jn Part I. 23	e. Did tobacco use contribute to the cause of death?
Records,	quire in slg uld bu	d be	end- stage demention due to Al	heiner denem	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
00	s bee	olet		24	a. Was an 24b. Were autopsy findings available
	The law cate has	Completed			autopsy prior to completion of cause of death?
of Vital	ician: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Death (Chec	
\leq	Physician: this certificatal director, I	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	0.1	☐ Residence 6 ☐ Other (Specify)
	g Ph er th		27. Manner of Death 28a. Date of Injury 28b. Time of	of 28c. Injury at 28d. De	scribe how injury occurred
jo	ath. r: Aft	atlo	Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division	l or Attanding Phatter death. Diractor: After the in by the funeral	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Loc	cation (Street and Number or Rural Route Number,
	s afte	Cert	building, etc. (Specify)	City	v or Town, State)
	bour hour unar		29a. Certifier Check only	th occurred at the time, date and place, and due	to the cause(s) and manner as stated.
	To the Hospital or Attanding PI within 24 hours after death. To the Funaral Diractor: After the completely filled in by the funeral.	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at th	e time, date and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			Medant mo	D32518	8/6/05
	ALLI		30. Name and address of person who completed cause of death (Item 23a) (Type		
_	14)		Dr. Robert Guedenet 21 Wyand Drive	. Keedysville, MD, 217	56 / 301-432-2222
	Sta		31. Date filed (Month, Day, North 1 0 2005. Registry's Signature	And the second	
	Registr	ar		7	

			For State	State of Marylan	-	artment of H						
			Registrar 1. Decedent's Name (First, Middle, La	st)	Cei	lilicate of t	Jeani	2. Date of Deat	eg. No. 2	5 32Time of Death		
	Physicia		Helen Kale Hunt					Month August	Day Year 5 2005	4:15p ^M		
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			Location of Death		4c. County of De	1,120		
ı			Sunrise of Montgo	omery Village		Montgom Vill	ery age		Montgome	ry		
	Funeral		5. Social Security Number 6. S	- TT -		If Under 1 Year Months Days	age Munder 24 Hrs. Hours Min.	(Month, Day,	Year) C	inthplace (State or Foreign Country)		
	Director		244-32-7428 Usual Residence of Decedent	□M 281F 98	Yrs.			Mar 13,	1907 No	rth Carolina		
	/land	Ì	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits		
	Man B-1 sh iffed	to	Maryland Montgome	ery M	lontgon	nery Vill	age			1 XYes 2 ☐ No		
	or 28	Dire	10e. Street and Number	- 1 11.15		10f. Zip Code			0g. Citizen of What C			
	s 23a	by Funeral Director	19310 Club House		2 140 1	20886			United St			
	Items Items	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No	5. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puert	o Rican, etc.)	14. Race - Am Black, Wh			
920	urs af	by F	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White		
က်	72 ho	eted	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	s/Industry		
2	10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Montgomery Village 10d. Zip Code 10d. Citizen of What Cot 20886 United State 10d. Street and Number 10d. Zip Code 10d. Zip											
7	iled w lygier ther ti	S	Own Maiden Sumame)	Home								
Maryland 21215-0036	d be f antal h ced of	To Be	17. Father's Name (First, Middle, Last June A. Kale	ile								
ary	shoul nd Mari	ř	19a. Informant's Name/Relationship (, City or Town, State,	Zip Code)							
ž	and 2 alth a 27 is		Barbara Hunt-Wol	er/Daughter	709 0	wens Str	eet, Rocl	kville, M	Maryland 2	0850		
Baltimore,	of He right		20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation 3 ☐	Removal from State	lace of Dispo	sition (Name of matory of other place politan	Aug.	Date 8	20c. Location - City o Alexandr			
Ě	Pag tment tant: I		* 4 □Donation 5 □ Other (Special	5)	Cren	natory	2005		Virgini	•		
Ball	Department mpor in in in in in in in in in in in in in		21. Signature of Fuperal Service Nice						ral Home,	MD 20077		
	402.0		23a. Flart 1. Eyler the disease, or com	140089						rg, MD 20877		
l.			shock, or heart fall are. List only Immediate Cause (Final	plications that caused the death one cause on each line.			3,			Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	aCardiopulmon		rrest						
r	Examiner		Conversion to the secondarions	Dementia	,							
	P .≅	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ								
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Cerebrovascu		ccident						
8760,	icate be executed physician and s the burial-transit			Due to (or as a consequ	derice or).							
687	ficate physis the	edicai		_ d								
Вох	that the death certificed by the attending properties as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of de	,		
œ.	death	sicia	in the past 12 months? 1 Yes 2 X No	4 Pregnant at time of de		Other (specify)			Month	Day Year		
P. O.	at the 1 by th etachi	Phys	9 Unknown					00- 614-1				
	Se Co	by	Part II. Other significant conditions Coronary Art		uting in the u	nderiying cause giv	en in Part I.			to the cause of death? Probably 4 X Unknown		
Ö	w require been si should I	etec	Corollary Art	ery Disease								
Rec	The law	Completed						24a. Was an autops perform	ry prior to death?	autopsy findings available completion of cause of		
<u>a</u>		e Co	25. Was case referred to medical				26 Place of Dos	1 ☐ Yes 2 ath (Check only on		s 2 No		
5	Physician: r this certifica ral director, I	To B	examiner?	Hospital: 1 Inpatient 2 I	ER/Outpatier	nt 3 DOA Oth				ecity)Assisted		
10	ng Phy ter thi neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		/ at	28d. Describe ho	w injury occurred	Living		
Sio	death. ctor: Af y the fu	atic	2 Accident investigation	n			Yes 2 □ No					
Division of Vital Records,	l or Att after d Direct I in by I	Certification:	3 Suicide 6 Could not be determined		ome, farm, str /)	eet, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,		
	pital		29a. Certifier 1 Certifying P	nysician: To the best of my kno	wiedne deat	occurred at the tin	ne date and place	and due to the ca	auso/s) and manner a	as stated		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai	(Check only 2 Medicel Exe	miner: On the basis of examinal and manner stated.	tion and/or in	vestigation, in my o	pinion, death occu	rred at the time, da	ate and place, and du	ue to the cause(s)		
	To the Hospital within 24 hours a within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier	- 10-		29c. Licens	e number	, 29	9d. Date signed (Mor	nth, Day, Year)		
}	5		1/1/ mu	GIVE		1)2	9816	, /	tugus	+8,05		
			30. Name and address of person who				. #	D 1	11 25 00	2052		
		•	Radhey S. Mura	rka, M.D. 50 \ 32#Registrar's Signa	w. Edm	onston Dr	ive #604	Kockvi.	11e, MD 20	J854		
	Sta Registr			37 Registrar's Signa	. April	ule						

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	ertificate of h			ene • N2 N N S	271.52
	Dhysisi		1. Decedent's Name (First, Middle	, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		ROBE		JOHNSON	T		AUGUST 5	2005	5:26 P M
	Examin	er	4a. Facility Name (If not institution 746 Quince Ord	-	#T2	Gaither	Location of Death		4c. County of Death MONTGOME	
	Funeral		5. Social Security Number		LZ (In yrs. last birthda)) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Birth	
	Director		213-54-5988	Man 2□F	56 Yrs.	Months Days	Hours Min.	July22	,1949 Was	nplace (State or Foreign untry) SN , DC
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or I	ocation				10d. Inside City Limits
	Mary!	tor	MD Monto	omery	Gait	hersburg				1 XYes 2 ☐ No
	n 28a	irec	10e. Street and Number	7		10f. Zip Code		10	g. Citizen of What Co	untry?
	23e c	Funeral Director	746 Quince C				878		U.S.A.	
	er des	une	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent E Armed Forces? ed 1 X Yes 2 □ N	ver in U.S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
036	be filed within 72 hours after death with the Maryland nat Hygiene. do other then "neturel", or items 23e or 28e-f show event, the Medical Eranifrat must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1971	1 ☐ Yes 2X No	Specify:		Specify:	Black
21215-0036	72 ho	Completed	15. Decedent	's Education	(Giv	edent's Usual Occup	during most of work	rina	6b. Kind of Business/l	•
121	within 900 within 100	mpl	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retired edical T	1)			Institute ealth
	e filed within al Hygiene. other then '		12th 17. Father's Name (First, Middle,	Last)	171	eurcar 1		e (First, Middle, M		Carcii
lan	should be nd Mental marked o	To Be	Henry	Johnson	sa West					
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic es once.		19a. Informant's Name/Relations		19b. Mai	ling Address (Street	and Number or Rur	al Route Number,	City or Town, State, Z	rsburg, MD
Z ()	and 3		Venessa Johns	son- wile		Quince cosition (Name of ematory or other place		_	Oc. Location - City or	
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation				Laurel,			
텵	artme ortant injury		* 4 ☐ Donation 5 ☐ Other (S) /_/	MD Nat	ional Pa 22. Name and Addre	ss of Facility S	nowden	Funeral 1	Home, P.A.
B	Dep Imp any	-	e enp	THOCK	260	246 N.	Washing	ton St	Rockvill	e,MD20850
			23a. Part1. Enter the disease, or shock, or heart tallure. List	only one cause on each lin	е.				st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	- ARTENIOSC	LEPOTIC CA	adiouascu	LHR DISEM	750		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):					
		Jer	Sequentially list conditions, I any, leading to minimediate	b. Due to (or as a	a cunsaquence of):					
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
90,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
68760,		edical		d.						
Box (eath certific attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of deli	very
	death	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1 □ Live birth 4 □ Pregnant at 9 □ Unknown		☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
<u>Р</u> О	nat the ded by the destached	Phy	9 Unknown Part II. Other significant condition		ut not reculting in the	undorhina cauca an	en in Port I	23a Did tohi	acco use contribute to	the cause of death?
ds,	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	d by	Fait II. Other significant condition	in a continuenting to death be	at not resulting in the	dilicertying cadae giv	on arranci.		s 2□No 3□Pro	
Records,	w require been si should I	ompleted						24a. Was an	24b. Were au	topsy findings available
	The lav ate has page 2	ошр						autopsy perform 1 Yes 2	prior to d	completion of cause of
Vital		Be C	25. Was case referred to medical examiner?	2-170			26. Place of Deat	th (Check only one		
of V	Physician: this certific ral director,	2	1 XYes 2 □ No	Hospital: 1 ☐ Inpatie			4 Nuising H		nce 6 Other (Spec	cify)
		:lon:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig		y 28b. Time Year) Injury	Wor	yat k? Yes 2 □ No	28d. Describe how	w injury occurred	
Division	or Attendi after death. Director: A d in by the fu	ertification:	3 ☐ Suicide 6 ☐ Could I	not be 28e. Place of Inju	ury - At home, farm,				eet and Number or Ru	ral Route Number,
á	spitel or A ours after nerel Direc filled in by	Cert	4 Homicide	building, etc	c. (Specify)			City or Town,	51816)	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune		(Check only 2 Medical	g Physician: To the best of Examiner: On the basis of	examination and/or					
	To the Hos within 24 h To the Fun completely	Medical	29b. Signature and title of certifie	and manner sta	ited.	29c. Licens	e number	29	d. Date signed (Monti	h, Day, Year)
	-3-3		14	- MP (01	ME)	O	5236	f	106054 8, 20	10 S
•	>		30. Name and address of person	who completed cause of d	eath (Item 23a) (Typ	e, Print)	LIE. MAS 9			
				jects / this. Itte	o coconnelly	KE, MOCKU				
	Sta Regist		31. Date filed (Month, Day, Year) AUG 0 9	2005 32. Fegistra	ar's Signature	parke				

			1 - For State Registrar	State of Ma		nd / Depa		t of H	ealth a	and M	lental Hy	giene	91DIE.	271.50
	Physic /Medi Examii	cal	Decedent's Name (First, Middle, Last Alberto F 4a. Fecility Name (If not institution, give Paint Branch F	Krsul street and number)	Liv	ving		Town, or	Location phi	of Death	2. Date of De Month Augus	Day 4c. Cou	Year 200 unty of De	5 6:45 A
	Funeral Director			x 7. Ag ☐ M 2☐ F	9 (In yrs. 78	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Feb. 1.	rth ay, Year) 2, 192	9. B	irthplace (State or Foreig Country) Gentina
	the Maryland 28a-f show otilitied at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome 10e. Street and Number	ry	10c. Ci	ty, Town or Lo	Chevy		se		· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limit
	h with t	al Dir	4515 Willard Aven	ue #711			10f. Zip	208	15			10g. Citizen	of What C entir	•
030	d within 72 hours after death with the Maryland jiene. r then "natural", or Itams 23a or 28a-f show Its Moulcal Exemple must be notified at	by Funeral Director	11. Marital Status 1☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 24 N If Yes, Give Year or Dates:			Was Deced if Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	D- 14. F		nencan Indian, lite, etc.
Maryland 21215-0036	d within piene. r than "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5	+)		tient's Usua kind of wor DO NOT us pervi	rk done a se retired,	ition Juring mos	t of worki	ing	16b. Kind o		s/Industry er Center
yiana,	should be filed of Mental Hygie marked other imatic evant.	To Be C	17. Father's Name (First, Middle, Last) Andres Krsul						Urs	ula	(First, Middle,	n		
Mai	nd 2 sh alth and 27 is n ir traun		19a. Informant's Name/Relationship (Ty Ursula B. Henjes,								I Route Number Chevy			Zip Code) Yland 20815
ващтоге,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	0	Place of Dispo cemetery, crem repolit	sition (Nam natory or of an Crea	ne of ther place ratory	7	Aug.	ate 4, 2005	20c. Location	on - City o ndria	r Town, State a, Virginia
Dall	22. Name an Donald 4400 P.									y ardt 1 Ro	Funera ad, Bel	al Home Ltsvill	P.	A. D 20705
	Inysician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	he cause on each line Hyperka Due to (or as a	e. lemia	h. Do not enti	er the mode	e of dying	, such as	cardiac o	r respiratory a	rrest,	•	Approximate Interval Between Onset and Death
	rate be executed we hysician and hysician and the burial-transit and	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Cardiac Due to (or as a	i conseq	uerice ofj.	a 							
. 204	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of the first outcome of the first outcome of the first outcome of the first outcome of the first outcome o	2 Feta	I death 3	Ectopic pre						Date of de	elivery Day Year
100	law requires that the as been signed by th 2 should be detache	by	Parkinson's Disc		it not resi	ulting in the ur	iderlying ca	luse give	n in Part I.					o the cause of death?
	The law re ate has be- page 2 sho	Completed	Hypertension Alzheimer's								24a. Was autop perfo. 1 \(\text{Yes} \)	rmed?	b. Were a prior to death?	utopsy findings available completion of cause of
VILA	Physician: The this certificate ha ral director, page	Be	25. Was case referred to medical examiner?	lospital:						of Death	(Check only o			
5	Attanding Phys rr death. actor: After this by the funeral di	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injur (Month, Day		28b. Time of Injury		c. Injury Work	4X 140	2	ne 5 Resid			ecify)
-	in Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At ho . (Specify	ome, farm, stre	et, factory,	office		2	Bf. Location (S City or Tow	Street and Nui vn, State)	nber or R	ural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one)	ician: To the best of ter: On the basis of and manner stat	examınal	wledge, death tion and/or inv	occurred a estigation,	t the time in my opi	, date and nion, deat	d place, a h occurre	nd due to the o	cause(s) and i	nanner as	s stated. e to the cause(s)
d	To the To the Comple	Me	29b. Signature and title of certifier	Pal				License	number 454	(7		29d. Date sign		
	2		30. Name and address of erse who co	mpleted cause of de	ath (Item	23a) (Type, F	Print)						7,	2003
	Sta Registr		Dr. William Critte 31. Date filed (Month, Day, Year) AUG 08 20	32. V gistra	r's Signal	buse A		#J)	, La	mer	, MD 20	,,,,,		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ruth R. Kahn July 29. 2005 2:00 P. /Medical 4a. Eacility Name (If not institution, give street and number)
Brighton Gamens 4b. City. Town, or Location of Death 4c. County of Death Examiner 5555 Friendship Blvd. Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, **Funeral** 1 M 2 √F Months 83 217-42-1499 Yrs Director June 14, 1922 Pensylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ahow the Medical Examiner must be notified at Chevy Chase Maryland Montgomery 1 ☐ Yes 2 ☐ No Director or 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5555 Friendship Blvd. 20815 Itams 23a United States init. Pages 1 and 2 should be filed within 72 hours after death i ariment of Health and Mental Hygiene.
ortant: If itam 27 is marked other than "netural", or Itams 238 noting of their traumatic event, It & Medical Erash ret insual. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Fashion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rueben Salkever Eda Spector ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 617 Watts Branch Parkway, Rockville, MD Larry Kahn/ Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Geo. Wash. University July 29
Medical Center 2005 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. ' 4 ☐ Donation 5 ☐ Other (Specify) Signature f Funeral Service censes 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma of the Lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate Due to (or as a cons- uence of): Examiner cause. Enter Underlying Cause (Disease or injury burial-transif or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records. been signe should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 ther (Specify) Assisted 1 ☐ Yes 2√2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Living 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident hours after deat 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0013187 August 4, 2005 ath (Item 23a) (Type, Print) 30. Name and address of person who completed cause of Neill Kennedy, M.D. 5530 Wisconsin Avenue, Chevy Chase, MD 31. Date filed (Month, Day, Year)
AUG 0 32. Resistrar's Signature State 5 2005 Registrar

		•	1 = For State Registra/AMEND#7perFH8	State of M	laryland Do		artment rtificate			nd Me		Reg. No.		2	74.55
	Physicia		1. Decedent's Name (First, Middle, L. Charlotte KOPIT	ast)							2. Date of D August		2005 ^{Year}	12	me of Death 2:45 Рм
	/Medic Examin		4a. Facility Name (If not institution, gi 8100 Connecticut						Location of Chase				County of De		
	Funeral Director			Sex 7.A 1□M 2∏TF	ge (In yrs. la 97 -8 (3 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of B June, D	20, Year	917 ^{9. Bi}	rthplace (State or Foreign Ork
	Maryland e-f ehow Ified el	tor	10a. State 10b. County Maryland Montgo	omery		, Town or Lo									side City Limits
	h with the 23a or 28	Funeral Director	10e. Street and Number 8100 Connecticut	Ave. Apt	<i>#</i> 516		10f. Zip	Code .0815					ted St		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "neturel", or items 23s or 28s-f show ampoints it item 27 is marked other then "neturel", or items 23s or 28s-f show ampoints in items and items are not appeared in items and items are not ited at an once.		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 V If Yes, Give Year or Dates	? No	1	Was Deced If Yes, spec			in? (Spe , Puerto F	cify Yes or N Rican, etc.)	lo-	14. Race - Am Black, Wh Specify: W	ite, etc.	dian,
21215-0036	l within 72 ho iene. r then "netui the Medical	Completed by	15. Decedent's E (Specify only highest g.		5+)		dent's Usua kind of wor DO NDT us 1espe	k done d e retired)	uring most	of workin	g		partme		ore
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	and 2 should lalth and Men 27 le marke er treumatic		19a. Informant's Name/Relationship William Kopit, So				-				Route Num Lesda,		or Town, State,	Zip Code)
Baltimore,	Pages 1 annual of He		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		_ 06	lace of Dispo emetery, crer nt Hop	natory or of	ther place	y A		ate st 7, 1		cation - City o Hasti New	rTown, S ngs c York	n Hudson
Balt	permit. Departr Imports any Inj		21. Signature of Funeral Service Lice	ensee	,	22	2. Name an	d Addres	s of Facility	Torc Wash	hinsk Carro Lington	Heb n,DC	rew Fur	neral	Home
8760,	cate be executed /Medical Examiner and physician and the burial-transit	dical Examiner	shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a Due to (or a	s a consequ gestiv s a consequ	uence of): ve Hea uence of):			e						val Between at and Ceath
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	quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying ca	ause give	n in Part I.			I tobacco ι] Yes 2	use contribute	to the cau Probably	se of death?
al Records,	icien: The law requir certificate has been si rector, page 2 should l	e Completed	25. Was case referred to medical								per 1 ☐ Yes	opsy formed? 2 \(\text{\text{No}}\)	prior to	completion	ndings available on of cause of
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Division o	ding After fune	Certification;	27. Manner of Death 1 Natural 2 Accident 3 Suicid 4 Homicide 2 Accident determine	be 2 e. Place of I		28b. Time or Injury ome, farm, str	м		at ? ∕es 2 □ N	No			nd Number or i	Rural Roul	le Number,
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifie 1 Certifying F (Check only one) 1 Medical Extensions)	Physician: To the besiminer: On the basis and manner:	of examinal	wledge, deat tion and/or in	h occurred vestigation,	at the tim	e, date and inion, deat	d place, a	nd due to the	e cause(s) e, date and	and manner and du	as stated. ue to the c	ause(s)
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	, -		30. Name and address of person whe Alan R. Mon					t Av	e, #1	.03	NW Was	shing	ton, De	200	15
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	land		Usual Residence of D 10a. State 1	ecedent 10b. County		10c. Ci	ty, Town or Lo	cation								10d. Inside 0	City Limits
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	ba filed within 72 hours after death with the Maryland hal Hygiene. od othar then "neturel", or Items 23e or 28a-f show event, it e Madical Ers nit er mat be neitlind at	Funerai Director	10e. Street and Numb		1 D 1			10f. Zip							of What Cou		Americ
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	of Health item 27		20a. Method of Dispos	sition		20b. I	 Place of Dispo cemetery, crer	sition (Nan	ne of	e)		Date	20c.	Location	n - City or T	Town, State	
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Baltimore,	permit. Pages Department of Importent: If it any injury or o		21. Signature of Fune	ral Service Lio	ensee	ti						s-Rina Ave Si					
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	To the Hospitel or At within 24 hours after of To tha Funeral Direct completely filled in by	edicai		Medical Ex	Physician: To the aminer: On the ba and manr	isis of examina	ation and/or in	vestigation,	in my op	e, cate an pinion, dea	th occurr	ed at the time	, date a	s) and n nd place	manner as : e, and due !	stated. to the cause((s)
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			30. Name and addres	ss of person who ha Arun		e of death (Iter 301 Geo			#20	19. S-	ilve:	r Sprin	10.	MD 5	20902		
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	Q .		Decedent's Name (First, Middle, Last)	R _b	001	incate or	Death	2. Date of De	ath Day	3. Time of Death	
	Physici /Medio		Bernice L	evine				08	05 2	005 330 AM	
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street 125-14-3535 4a. Facility Name (If not institution, give street) 5. Social Security Number 6. Sex 10 M	reater Was 7. Age (In yrs. Ias 95	hing history) Yrs.	4b. City, Town, o	If Under 24 Hrs Hours Min	S. 8. Date of Bir	th	of Death OMENU Bithplace (State or Foreign Country) New York	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loc	ation				10d. Inside City Limits	
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	th wit	alD	4405 Kalmia Street			20	853		United	States	
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "netural", or Items 23e or 28e-f show gater traumatic event, the Medical Examiner rust be notified at	by Funeral Director	1 Never Married 2 Married 1	/as Decedent Ever in U.S. rmed Forces? □Yes 2∑No Yes, Give ear or Dates:		/as Decedent of H Yes, specify Cuba □ Yes 2X No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	- 14. Race Black Specify:	e-American Indian, k, White, etc. : : White	
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ary	shou and M s mar umat	_	19a. Informant's Name/Relationship (Type, Pr		19b. Mailing	Address (Street		lural Route Numbe			
	and 2 salth a n 27 li		Jerome I. Levine, So				reet, Ro	ckville,	MD 208	853	
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov		ce of Dispos netery, crem	ition (Name of atory or other plac	ce)	Date	20c. Location - 0	City or Town, State	
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Bal	permit. Pages 1 Department of H Important: If Ite any injury or of once.		21. Signature of Funeral Service Licensee		10	91 Rockv	rille Pik	cal Direc ke, Rocky	ville, MI	nc. D 20852	
Physician /Medical Examiner be executed be brighted and strength transit transit strength from the print of t		23a. Part1. Enter the disease, or complications that caused the orath. Do not enter the mode of dying, such as cardiac or respond to the product of the prod								Interval Between Onset and Death OWL MANN	
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Vital Records,	The ate h page	Completed							rmed? pr	/ere autopsy findings available rior to completion of cause of sath? ☐ Yes 2 ☑ No	
VII.	Physiclen: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner?	al:		Oth		ath Check on o			
of		: To	TE TES ZENO	a. Date of Injury 2.	R/Outpatient 8b. Time of	3☐ DOA 28c. Injun	4 Wursing I	Home 5 Resid	lence 6 Other		
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Division	To the Hospitel or Attend within 24 hours after death To the Funerel Director: / completely filled in by the f	Certification:	3 Suicide 6 Could not be	e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	e Hospi n 24 hou e Funer letely filk	edical	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: O	To the best of my knowled on the basis of examination and manner stated.	edge, death on and/or inve	occurred at the tin estigation, in my of	ne, date and plac pinion, death occ	e, and due to the durred at the time,	cause(s) and man date and place, ar	nner as stated. nd due to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed	(Month, Day, Year)	
)	7		I fric 7. Jul			mo :	37464	+	August	5,2005	
	2		30. Name and address of perso who complet	ed cause of death (Item 2			MA I	KKal	12114, 1	1.0	
	ai.	22	31. Date filed (Month, Day, Year)	32. Pagistrar's Signatur		cville,	Marylo	and	798	2	
	Sta Registr	200	ALIG 0.8 2005	Marie &	5 Ap	BASS !)				

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Tarber's Name (Prest, Modele, Last) Hazold Wallace	mpldm	Elementary/Secondary (0-12)			d)	0.	11					
Harold Wallace Sale Informatic Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Paural Pouls Number, City or Town, State, Zip Code) 38 Falcon Bridge Rd., Berlin, MD 21811 20a. Mathod of Disposition 1 United 2 United Street 20a. Location - City or Town, State 20b. Place of Disposition 1 United 2 United Street 20a. Location - City or Town, State 20b. Place of Disposition 1 United 2 United Street 20a. Location - City or Town, State 20b. Place of Disposition 1 United 2 United Street 20a. Location - City or Town, State 20b. Place of Disposition 1 United 2 United Street 20a. Location - City or Town, State 20b. Place of Disposition 1 United 2 United Street 20a. Location - City or Town, State 20b. Place of Disposition 1 United 2 United Street 20a. Location - City or Town, State 20b. Place of Disposition 1 United 2 United Street 20a. Location - City or Town, State 20b. Place of Disposition 1 United 2 United Street 20a. Location - City or Town, State 20b. Place of Disposition 1 United 2 United 2 United Street 20a. Location - City or Town, State 20b. Place of Disposition 1 United 2 United Street 20a. Location - City or Town, State 20b. Place of Disposition 1 United 2 United Street 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location - City or Town, State 20a. Location -	CO -		ast)	nomemaker	18. Mother's Name (First, A							
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Cape Henlopen Crem. 8/11/2005 Frankford DE		20a. Method of Disposition	20b. Place	of Disposition (Name of	Date							
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1 Pes 2 No 3 Probably 4	ched for use as I	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No										
24a. Was an autopsy performed? 24b. Were autopsy find prior to completion death? 25b. Was case referred to medical examiner? 25b. Was case referred to medical examiner? 25b. Was case referred to medical examiner? 25b. Was case referred to medical examiner? 25b. Was case referred to medical examiner? 25b. Was case referred to medical examiner? 25b. Was case referred to medical examiner? 25b. Was case referred to medical examiner? 25b. Was case referred to medical examiner? 25b. Was case referred to medical examiner? 25b. Place of Death (Check only one) 25b. Place of Death (Check only one) 25b. Place of Injury 25b. Time of I	0	Part II. Other significant condition	s contributing to death but not resulting	g in the underlying cause gi	ven in Part I. 23e		tribute to the cause of death?					
autopsy performed? Yes 2 No						1 res 2 □ No	3 ☐ Probably 4 ☐ Unknot					
25. Was case referred to medical examiner? Total Personal Perso	α Q					autopsy performed?						
27. Manner of Death 1 Norsing Home 5 Hesidence 6 Unter (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 3 Suicide 4 Homicide 28b. Time of Injury M 28c. Injury at Work? 3 Suicide 4 Homicide 28b. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route) City or Town, State) 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	Se C											
27. Manne of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 1 Planting 1 Pla	D 2		Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 DOA	her: 4 Nursing Home 5 🖺	Residence 6 □Oth	ner (Specify)					
29a. Certifier (Check only) (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		1 ☑Natural 5 ☐ Pending investiga	(Month, Day Year)			cribe how injury occur	red					
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	ed in by t	determin	ed 28e. Place of Injury - At nome,	farm, street, factory, office			ber or Rural Route Number,					
29b. Signature and title of certifier 29c. License number 29d. Date signed/(Month, Day, Ye.) 444283 29d. Date signed/(Month, Day, Ye.)	icai	(Check only 2 Medical Ex	xaminer: On the basis of examination	dge, death occurred at the ti and/or investigation, in my	me, date and place, and due opinion, death occurred at the	o the cause(s) and ma time, date and place,	anner as stated. and due to the cause(s)					
	woo N	29b. Signature and title of certifier	12 D.O	29c. Licen:	se number 4283	29d. Date signe	d (Month, Day, Year)					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Durker 9733 Here Bende	5	30. Name and address of person w	ho completed cause of death (Item 23)	a) (Type, Print)	Man. A	Tame 5	Ben O. M					

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND#7perFH8/5/05,BMW,MoCo Certificate of Death Reg. Not 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ju₁y 2005 8:35 Sin Leung /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 4522 Muncaster Mill Road Rockville 8. Date of Birth (Month, Day, Year)
July 13, 1 7. Age (In yrs. last birthday) 75.76 Yrs. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. Director 223.41.3929 Canton China Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23e or 28e-f show 10c. City. Town or Location 10d, Inside City Limits 10a State 10b. County ral, or Itams 23a or 28e-f show Examiner must be notified at 1 Yes 2X No Directo Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 U.S.A. 4522 Muncaster Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. If Yes, Give Year or Dates: Completed by 3 X Widowed 4 Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider, Surname) Be Lee Tsang Ho Chan ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is 4522 Muncaster Mill Road, Rockville, MD 20853 Christine Ka / Granddaughter othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition injuryor 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemet. 08/06/2005 Silver Spring, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service License any in 11800 New Hampshire Ave. Silver Spring, MD 20904 Nance 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ascites Priysician Malignamdisease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ovariar Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month ŏ Day Year 5 ☐ Other (specify) be detached Records, P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 🗆 Yes 2 →No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 1 Yes 2 No 4 Nursing Home 5 PResidence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury or Attanding 1 Natural 5 Pending 1 Tes 2 No death. investigation 2 Accident after death 6 Could not be determined To the Hospitel or Atta within 24 hours after de To tha Funaral Directo completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 3rd, 2005 MD OT GII 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUPTA 121 congressional lang Rockelle, MD 20852 , MD. ,#402 GHANSHYAM 31. Date filed (Month, Day, Year)
AUG 05 Registrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

			1 - State of Maryland /	-	artment			and M	lental Hy	giene Reg. Né			271.60
ı	Physici		Decedent's Name (First, Middle, Last) VIRGINIA S. MILLER						2. Date of De Month AUGUST	ath Da	7005 Y	<i>∃</i> ∋ar	3. Fime of Death 1:00am M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	-	4b. City,	Town, or	Location o	f Death	4c. County of Death			1.00am	
			415 Russell Ave, #502		Gait	hers	burg			Mo	ontgom	ery	
	Funeral Director		5. Social Security Number 579-60-9320 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last bit) 97	irthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month Da Nov 5,	1907	9. 7 V	Birthpl Coun int	ace (State or Foreign try) On, IA
	ow ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	vn or Lo	cation							10	Od. Inside City Limits
	Many a-f sh	tor	MD Montgomery Gaith	ners	burg								¹X Yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip					10g. Cit	tizen of Wha	t Coun	try?
	s 23e		415 Russell Ave #502			877					ed St		
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel', or Items 23e or 28a-1 show any finury or other treumetic event. It is Markela Examinator must be notified at anone.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	(was Decedor If Yes, special 1 Yes 2		Spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		14. Race - A Black, N Specify:	White, e	
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/land	uld be file Mental Hy Irked oth	To Be (17. Father's Name (First, Middle, Last) George Albert St. Clair						(First, Middle, Mae Wi		Sumame)		
, Mar	and 2 sho halth and I 127 is ma								Noute Number				Code)
Baltimore, Maryland 21215-0036	Pages 1: nent of He ont: If iten			ry, crer	sition (Nam natory or oth ort C	her place			ate)5		ocation - City exandr		
Balt	permit. Departn Importe any injk		21. Signature of Funeral Service Licensee	22	Name and	Addres	of Facility	Jose	eph Gaw	ler'	s Fun	era:	1 Home 20016
	Physician	l g	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Concestive Heartsulfing in death)	not ent	er the mode	of dying					8.00		Approximate Interval Between Onset and Death 4 Months
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	rcuted nd Iransit	Examiner	Sequentially list conditions, if any, leading to immediate tause. List Uncertainty Cause (Disease or injury that initiated events resulting in death) Last	of):									
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Vital Records,	The law ate has b page 2 si	Completed						_	24a. Was autop perfo 1 Yes		prior	to com	sy findings available pletion of cause of
<u>Ita</u>	i cien : Th certificate ector, pag	Be (25. Was case referred to medical examiner?			_			(Check only o	ne)			
Division of	ing Phys	tion: To	1 X Natural 5 ☐ Pending (Month, Day Year)	utpatien Time of Injury		c. Injury Work	at	2	ne 5 Resid			Specity)	
Divisi	n ji te	Certification;	2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (City or To								(Street and Number or Rural Route Number, own, State)		
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	e, death	occurred a restigation, i	the time	e, date and nion, death	place, a	nd due to the o	ause(s) date and	and manner place, and	r as sta due to t	ted. he cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier		29c.	License					e signed (M		
1	ਹ		Peiscellu Collabar dy on			P C	1794	1		Aug	rust.	3,	ک٥٥٥
,			30. Name and address of person who completed cause of death (Item 23a) Priscilla Callahan M.D. 911 Russ	(Турө, sell	orint) Ave,	Gait	hersl	ourg	MD 208	77			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 8 2005 32 degistrar's Signature	for	wie								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Month **Physician** Malhotra August 2, 10:10 \mathbf{P}^{M} Lal /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Casey House If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 1**X**M 2□ F 78 January 17, 1927 India Director 215-53-1837 Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r than "neturel", or Items 23a or 28a-f show It e Medical Examiner must be notified at 1 ☐ Yes 2 K No Gaithersburg Directo Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20886 20203 Swallow Point Road India Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesperson **Business Supplies** 12 permit. Pages 1 and 2 should be filled Department of Health and Mental Hyg Importent: if item 27 is marked other any injury o<u>r</u> othar treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gyan Devi Kapoor Girdhari Lal Malhotra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20203 Swallow Point Road Gaithersburg, Maryland 20886 injury or other th Reetu Pruthy - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Northern Virginia Crematory 8/5/05 Arlington, Virginia ' 4 Donation 5 Other (Specify) 22. Name and Address of Facility Arlington Funeral Home 21. Signature of Funeral Service Licensee 3901 North Fairfax Drive Arlington, Virginia 22203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallers. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain Tumor Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2**X** No 1 Tes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation XVatural 1 ☐ Yes 2 ☐ No Accident after death the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Hospital 29a. Certifier 1 Xcertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature D35635 August 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Maryland 20855 6001 Muncaster Mill Road Joseph Kaplan

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) AUG 05

2005

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Division To the Hospital or Attendi within 24 hours after death. To the Funeral Directur. A completely filled in by the ti	edical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinone)	ician: To the best of my knowled er: On the basis of examination and manner stated.	lge, deal and/or ir	h occurred a vestigation,	it the time, in my opini	date and pla ion, death o	ace, and due to the ccurred at the time,	cause(s) and date and place	manner as : e, and due t	stated. o the cause(s)
To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	. ^		29c.	License n	umber		29d. Date sig	ned (Month,	Day, Year)
5		My salelee VI	as Greak	nD	D	1365	7		July 3	30,20	05
		30. Name and address of person who co	mpleted cause of death (Item 23	a) (Type	Print)	י דיק מ	- RIA	TOODE	פ הדל	1511	
0.0		31. Date filed (Month, Day, Year)	mpleted cause of death (from 23) REGOR, 70 0 0 37 Registrar's Signature	40	I The Silve	1-21	1 13150	- 111 VICE		-211	
St Regist	ate rar	AUG 0 5 200	5 Know &	15	and I						

		1	State of Maryland / Department of Health and 1- State M.FD#10g, 15, 16a/hperTNF.8/5/05, EMW, MCCertificate of Death		giene eg. No. 2005 27463
			1. Decedent's Name (First, Middle, Last)	2. Date of Dea	th.Tr 1 2 25 2005 3. Time of Death
	Physicia	an	HENRIFER GERMAN MURALES-MACEDO	Month	Day Yeer 5 7.8A.M.
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number) HOME 4b. City, Town, or Location of De	eath	4c. County of Death
			9401 THURNHILL RD SILVER SPRING	5	MONTGOMERY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H Months Days Hours Miles Mi	in. (Month, Day	(Year) Country)
	Director	-	216-50-8852	JAN/22	2/47 LIMA, PERO
	and	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	i	10d. Inside City Limits
	Maryl 1 sho led a	ō	MD Montgomery SILVER SPRING		1 @ Yes 2 □ No
	28a	Directo	10e. Street and Number 10f. Zip Code	1	10g. Citizen of What Country? USA
	h with		9401 THORNIHILL ROAD 20901-48	833	1-125735H
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
98	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene and other than "naturel", or tems 23a or 28a-f show event, the Madical Examinar must be multiled at		1 Never Married 2 Married 1 Yes 2 No If Yes. Give 1 Yes 2 No Specify:	FRUVIAN	Specify: LATIN MINED
Ö	should be filed within 72 hours aft id Mental Hygiene. marked other than "naturel", or matic event, the Madical Exami	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Industry
21215-0036	in 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of w	working	,
72	with iene.	E.	Elementary/Secondary (0-12) College (1-4or 5+)5+ College (1-4or 5+)5+ College (1-4or 5+)5+	A TOP	Law
ğ	~ - 0 5	Be C	17. Father's Name (First, Middle, Last) 18. Mother's N	Name (First, Middle,	Maiden Sumame)
<u> a</u>	ould by Menta Marked Marked	10.		ELOUISE	
Maryland	2 sho and ! Is ma		19a. Informant's Name/Relationship (Type, Print) (MortHER) 19b. Mailing Address (Street and Number or	Rural Route Number	r, City or Town, State, Zip Code)
_	and lealth m 27 her tr	1 8	100 00 00		200. Location - City or Town, State
Baltimore,	Pages 1 nent of H int: If ite	l ÿ	1 Burial 2 Cremation 3 Removal from State		ROCKVILLE MD
Ē	riant Pa	1	'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	29-05	2090/
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or pother treumatic av pnce.		Allahina Russell 9401 THURNIAM	4 ROAD.	
				dia	Approximate
1	Pnysician	2 0	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Fui	XI U / I Onset and Death
	/Medical		Due to (or as a consequence of):		
	Examiner	_	Sequentially list conditions,	1,93.4	
	led nsit	nine	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events		r
	cate be executed obysician and the burial-transit	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
8760	e be (sicia)	dicai I	d		
9	g b	ledi			
Вох	death certifica e attending ph od for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery Month Day Year
	0 0 0	Physician/Me	in the past 12 months? 1		
P.0	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
ds,	ള ക്	d b		1 □ Y	res 2 no 3 Probably 4 Unknown
Š	w require been si should	ete	1)+43 (11)	24a. Was a	an 24b. Were autopsy findings available
of Vital Records,	The lav ate has page 2	ompieted			rmed? death?
ta		CO		1 ☐ Yes Death (Check only or	
<u> </u>		To B	examiner?	ng Home 5 Resid	lence 6 ☐Other (Specify)
0	ng Physter this neral di			28d. Describe h	ow injury occurred
Siol	endir eath. or: Al	catio	2 Accident investigation 3 Suicide 6 Could not be 288 Place of Injury - At home farm street factory office	Ont Leasting (C	Phreat and Number of Paris Paris Number
Division	tel or Attending PI s after death. al Director: After the	Certification;	3 Suicide 4 Homicide 4 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tow	Street and Number or Rural Route Number, rn, State)
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai C		ace, and due to the occurred at the time, o	cause(s) and manner as stated. date and place, and due to the cause(s)
		Me	29b. Signature and title of certifier $y \land C \vdash A \vdash A \vdash A \vdash A \vdash A \vdash A \vdash A \vdash A \vdash A \vdash$	2	July 25th 2005
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NASHID II	A CHA!	20901
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 0 5 2005		

		_	1 - For State of Maryland / Department Certificate		Reg	1. NR. 0.05	27465	
	Physicia		Decedent's Name (First, Middle, Last) HAROLD THOMAS McBAIN		2. Date of Death Month AUGUST	Day Year 6 2005	3. Time of Death 5 09:24 A ^M	
	/Medio Examin			own, or Location of Death		4c. County of Deat	h	
			SHADY GROVE ADVENTIST HOSPITAL RO 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	CKVILLE Year If Under 24 Hrs.	8. Date of Birth	MONTGOME	ERY hplace (State or Foreign	
	Funeral Director			Days Hours Min.	(Month, Day,) March 24	rear) Co	untry) aryland	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
	Maryl	tor	Md. Montgomery Gaithersbur	a			1 Yes 2 □ No	
	or 28c	Funeral Director	10e. Street and Number 10f. Zip C	ode 20877	10	g. Citizen of What Co	-	
	death v	erai	123 Tulip Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto	ecify Yes or No-	United S		
98	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "neturel", or Items 23e or 28e-f show event, I've Medical Exacili or cost be notified at		1 Never Married 21 Married 1 ⊠Yes 2 No 1952 -	y Cuban, Mexican, Puerto ⊠ No <i>Specify:</i>	Rican, etc.)	Black, White Specify:	e, etc. White	
ő	ture!,	ed by	15. Decedent's Education 16a. Decedent's Usual	Occupation	10	Sb. Kind of Business/		
21215-0036	within 72 ene. than "nel	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		ing	Telephor	ne Company	
d 21	filed w Hygier Ather th		12 2 SYSCEMS II		e (First, Middle, Ma		10 00	
/lan	should be ind Mental marked c	To Be	George McBain	Lucy	Brow	n		
Maryland			1 1 21 1 1	Street and Number or Run Drive, Gait				
altimore,	Pages 1 and 2 nent of Health int: If item 27 I		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name cemetery, crematory or oth	er place)		Oc. Location - City or		
ıltim	그 문 원 중	i	4 □ Donation 5 □ Other (Specify) Forest Oak Ceme 21. Signature of Funeral Service Licensee 22. Name and	Address of Facility 1 H. Barber	.0/05	Gaithersk	ourg, Ma.	
Ä	Depar Important in such in suc		Murey W Barber P. O.	Box 5038,	Laytonsv	ille, Md.		
All Market	Priysician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause. Enter Underlying Cause (Disease or injury that initiated events	Infarch	0 1		Approximate Interval Batwaen Onset and Death	
68760,	death certificate be executed e attending physician and of for use as the burial-transit	edical	resulting in death) Last Due to (or as a consequence of): d					
O. Box	that the death certific ed by the attending p detached for use as I	Physician/Mo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (special contents)			23d. Date of del Month	ivery Day Year	
rds, P.	sign sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	use given in Part I.		cco use contribute to		
I Records,		Completed			24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Othor	h (Check only one,			
of	ig je	tion: To	1 Inpatient 2 PENOutpatient 3 DOA	4 Nursing Ho	me 5 Residen 28d. Describe how	ce 6 Other (Spec	oify)	
Division	el or Attendi s after death. el Director: A ed in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,	
	To the Hospitel or Atte within 24 hours after de To the Funerel Direct completely filled in by ti	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, is and manner stated.					
) .	20+1	M	29b. Signature and title of certifier 29c. D	License number	A-	Date signed (Monti	1, Day, Year)	
	V .		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin McGreivy, M.D. 9901 Medical Ce	enter Drive,	Rockvill	e, Md. 2	0850	
	Sta Regista		31. Date filed (Month, Day, Year) AUG 0 9 2005 32 Jegistrar's Signature					

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			State State	of Marylan				Mental Hygi	ene	
			Registrar		Cer	tificate of	Death	2. Date of Death	g. No. 2	1 2 Tirde htt Death
	Physicia /Medic		Decedent's Name (First, Middle, Last) MARY CATHER	INE WILL	HIDE PA	ATRICELL	I	August	8, 2005	3:08 P M
	Examin		4a. Facility Name (If not institution, give street and Homewood at Crumland F		4b. City, Town, Frederi	or Location of Deat	h	4c. County of E		
40			5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	9	Birtholace (State or Foreign
	Funeral Director		228-26-5092 1□M 2XI			Months Days	Hours Min.	March 5	, 1914 N	Maryland
	B ≱ = 2		Usual Residence of Decedent 10a. State 10b. County	10c. City	y. Town or Loc	cation				10d. Inside City Limits
	f sho	-0	Maryland Frederick	'	rederio					1 ☐ Yes 2 ☐ No
	r 28a-f	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	t Country?
3	238 o	al D	7407 Willow Road			2170			U.S.A.	
3	De lied within 72 hours after death with the Maryanu lat Hygiene. Nat Hygiene. do other than "neturel", or items 23s or 28s-f show event, the Madical Examination must be rivified at	by Funeral	1 Never Married 2 Married 1 Yes.	ecedent Ever in U. Forces? s 2 1 No Give		Vas Decedent of Yes, specify Cub ☐ Yes 2 12 No	Hispanic Origin? (S ban, Mexican, Puerl Specify:	specify Yes or No- to Rican, etc.)		American Indian, White, etc. White
5	ture!		15, Decedent's Education	r Dates:	16a. Deced	ent's Usual Occu	pation	1	16b. Kind of Busin	
3	nin 72 an "ne Medic	Completed	(Specify only highest grade complete	e_(1-4or 5+)	(Give I	kind of work done OO NOT use retire	during most of wo ad)	rking		
3	od will giene f. L.	Com		4	Tea	cher/Lib			Educati	on
		To Be	17. Father's Name (First, Middle, Last) Willie Zimmerman Willh	ide				me (First, Middle, N cocksdale	faiden Sumame)	
, a	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	F	19a. Informant's Name/Relationship (Type, Print)			-		ural Route Number,		
ž .	and 2 lealth m 27 i		Richard M. Willhide (N			orth Car: sition (Name of	roll Stre	et, Thurn	nont, MD	
5	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal fr	om State	emetery, cren	ge Cemet				Maryland
	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		'4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licenses	0 91	/ 2 2	Name and Addr BERT E.	ess of Facility &	SON, FUNE	ERAL HOME	ES, P.A.
	3 O E 8 0		23a. Part 1. Enter the disease, or complicate as the chock, or heart failure. List only one cause	at cabed the least	/	O FAST	MAIN ST.	THIRMINI	MIII / I /	Approximate
4	ากงูลเต่อก		Immediate Cause (Final	on each line.	11	+1/	. (.)	1./	Code	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	to (or a conseq	uence of):	VOSCO	1160	115	€	y = 15
	Examiner	Ĺ	Sequentially list conditions, b.	to (or as or need	591	tengio				y en 15
_	nsit	Examiner	cause. Enter Underlying	to (or as a demospo	ugrice or):					
ć	execu an and rial-tra		that initiated events	to (or as a conseq	uence of):					
00/00	cate be executed bhysician and the burial-transit	dlcal	d							
o X	certific Iding F	/Me	IF FEMALE: 23c. If yes,	outcome of pregna	incy				23d. Date of	f delivery
5	that the death certifii ed by the attending f detached for use as	Physiclan/Me	in the past 12 mooms?	ve birth 2 Feta egnant at time of d nknown		Ectopic pregnand Other (specify)	cy		Month	Day Year
cords, r	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing	o death but not res	ulting in the ur	nderlying cause g	iven in Part I.			te to the cause of death? Probably 4. — Whitenown
2	law reas bee	Completed						24a. Was ar autopsy	y prior	e autopsy findings available to completion of cause of
	: The cate h , page	Con						perform 1 ☐ Yes 2	ned? deaf	th? Yes 2□No
N I G	sicien certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	☐ Inpatient 2 ☐	ED/Outpation	30000		ath <i>(Check only one</i> Home 5 ☐ Reside		Spaciful
0 00	ding Phys h. After this funeral di	}	27. Manner of Death 28a. D	ate of Injury Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe ho		Зр в спу)
DIVISION	for Atten after deat Director: In by the	Certification;	3 Suicide 6 Could not be 28e. P	lace of Injury - At he uilding, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Str City or Town		or Rural Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifier 1 Certifying Physician: To (Check only one) 1 Medical Examiner: On the and	the best of my kno le basis of examina anner stated.	wledge, death	n occurred at the vestigation, in my	time, date and plac opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manne ite and place, and	er as stated. due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	/	20	29c. Licer D1642	nse number	29	od. Date signed (A	Month, Day, Year)
	7		30. Name and address of person who completed Casper E. Cline, III,	Cause of death (Item	n 23a) (Type, Vest 9t	Print) Th Street	, Freder	ick, Mary	land 217	01
To the second	Sta Regist	ate rar	31. Date filed (Month, Cay, Year) 2005	Registrar's Signa	ture for	of a				

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200 8-8-05

Many Patricelli

			1 _ State	State of Marylai		artment of H			ene . N2 0 0 5	271.67
			Registrar 1. Decedent's Name (First, Middle, Last)		061	tineate of t	Dealii	2. Date of Death	. NO. UUJ	3. Time of Death
ı	Physicia			RY, SR.				Month August	06 Year 2005	3:00 P ^M
ı	/Medic Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, o	r Location of Deat		4c. County of Deat	
	LXamiii	61	Casey House-Montgo	mery Hospic	e	Rockvi	11e		Montgome	ery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,)	(ear) 9. Birt	hplace (State or Foreign untry)
	Director		264.22.5615	^{2□ F} 76	Yrs.	Monard Bayo		Feb. 8, 19	929 Mia	mí, Florida
	and		Usual Residence of Decedent 10a, State 10b, County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Manyl f sho	5	Maryland Montgomer	sy S	ilver S	Snrino				1. Yes 2 □ No
	28e-	Director	10e. Street and Number	9 3	TIVEL	10f. Zip Code		100	j. Citizen of What Co	untry?
	3e or		11123 Easecrest Dri	ve		20902			U.S.A.	
	within 72 hours after death with the Maryland ene. than *naturel', or Items 23e or 28e-f show the Medical Examiner must be motified at	Funeral		Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, White	
9	after or Ite		1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☒ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	o rican, etc.)	Specify: B1	,
8	nours urel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						
ζ.	natu	Completed	15. Decedent's Educat (Specify only highest grade c	ion ompleted)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	8b. Kind of Business/	,
12	withlir ene. than	d m	Elementary/Secondary (0-12)	College (1-4or 5+) 4 Years		national		rector II	nternation	al YMCA
Maryland 21215-0036	filled Hygid Sther		17. Father's Name (First, Middle, Last)	4 Teals			18. Mother's Na	ne (First, Middle, Ma	iden Sumame)	
an	ld be ental ked c	To Be	Lewis Perry				Eliza	beth Elli	Ls	
ary	2 should be filed within 72 hours after death with the Marylan and Mantal Hygiene. Is marked other than "naturel", or Items 23e or 28e-1 show eumatic event, the Modical Examiner must be notified at	-	19a. Informant's Name/Relationship (Type	. Print)	19b. Mailir	ng Address (Street	and Number or Ri	ural Route Number, (City or Town, State, 2	Zip Code)
Š	alth a		Johnnie L. Perry/W	ife	11123	Easecre	st Drive	, Silver S	Spring, Ma	ryland 20902
Š.	of He		20a. Method of Disposition	(Place of Dispo	sition (Name of matory or other place	(e)	Date 20	c. Location - City or	Town, State
altimore,	Page nent of try of the try of th		1 ⊠Burial 2 □ Cremation 3 □ Ren '4 □ Donation 5 □ Other (Specify)	Ga	ate Of	Heaven Ce	eme. 8/11	/2005 Si	lver Spri	ng, Maryland
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Importent: It item 27 Is marked any injury or other treumatic evone.		21. Signature of Funeral Service Licensee	contre	H 1	Name and Addre INES-RINA 1800 New	ss of Eacility LDI FUNI Hampshir	RAL HOME, e Ave, Si	INC. lver Spri	ng, MD 20904
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the dea						Approximate Interval Between
ş.	Physician		Immediate Cause (Final disease or condition	End Stage A						Onset and Death
	/Medical		resulting in death)	Due to (or as a conse						
	Examiner		Sequentially list conditions. b			**				
	D iii	Examiner	Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	meuce of					
	and and I-tran	хаш	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):					
8760,	icate be executed physician and s the burial-transit	ᆵ			,					
687		dical	d							
	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	√Me	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of pregr					23d. Date of deli	very
Вох	death a atter	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of]Ectopic pregnancy] Other (specify)	<u>'</u>		Month	Day Year
о. О.	that the de ed by the detached	hysi	9 Unknown	9□ Unknown					- N	
<u>ر</u> م	res that igned b	by P	Part II. Other significant conditions contri	buting to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ğ	w require been sig should b		End Stage Parkinson	n				1 ☐ Yes	2□No 3□Pr	obably 4 🛮 Unknown
000	law re as bed 2 sho	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
ž	The ate has page	mo;						performe	id? death?	2□ No
ita	Physicien: The this certificate har all director, page	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one)		
×	Physic this ce al dire	2	1 ☐ Yes 2 🛣 No Hos		☐ ER/Outpatier		4 🗀 Nursing F			city) Hospice
n	ing P	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	k?	28d. Describe how	injury occurred	
Sio	Attending Physicien: r death. sctor: After this certific by the funeral director.	cati	2 Accident investigation 3 Suicide 6 Could not be	on the states the	lama fassi si		Yes 2 □ No	29f Lacation (Stre	et and Number or Ru	and Pouts Mumber
Division of Vital Records,	- 0 -	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, rann, sti eify)	еет, гастогу, оптсе		City or Town,		rai noble Nulliber,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physic	ian: To the best of my kr	nowledge, deat	h occurred at the tir	ne, date and place	a, and due to the cau	se(s) and manner as	stated.
	24 hr 24 hr 9 Fun	Medical		r: On the basis of examinand manner stated.						
	ro th within Fo th	Me	29b. Signature and title of certifier,	1)		29c. Licens	e number	290	I. Date signed (Montl	n, Day, Year)
	10		SHAT	n	-	14	11)18	A:	ugust 7, 2	2005
	i U		30. Name and address of person who com							
_			Charles Harrison,	M.D., 6001	Muncas	ter Mill	Road, Ro	ckville,	Maryland 2	20855
	Sta		31. Date filed (Month, Day, Year)	32. Panietrar's Sign	ature					
	Registi	rar	AUG 09 2005	Bown 1	U MAR	200				

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			State of Maryland / Department of Health and	-	
			1- For State Registrar Certificate of Death	•	Reg. No. 2005 27468
	Physicia	20	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	
	/Medic		Harvey S. Price	August	7 2005 0907 M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	h ,	4c. County of Death
	Funeral		MONTGOMERY GENERAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs		th (Y, Year) MONTGOMERY 9. Birthplace (State or Foreign Country)
h	Director		214-42-5519 1™ 2□F 62 Yrs. Months Days Hours Min.	08/20/1	942 NEW YORK
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Maryli f sho	tor	MARYLAND MONTGOMERY MONTGOMERY VILLAGE		1∑ Yes 2 No
	r 28a	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
	23a c	rai D	10001 DELLCASTLE ROAD 20886		U.S.A.
	er de:	nne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - American Indian, Black, White, etc.
39	urs aft	by	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify: Year or Dates:		Specify: WHITE
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show the Maxical Examiner must be mullified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wo	deina	16b. Kind of Business/Industry
2	ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	9	DDIVAGE DDAGGIGE
5 0	be filed v ntal Hygie od other t	Co	5+ ATTORNEY 17. Father's Name (First, Middle, Last) 18. Mother's Name	me (First, Middle,	PRIVATE PRACTICE
an	lid be lental rked o	To Be	MURRAY PRICE EDNA		KAHN
Maryland	2 should and Men is marke aumatic	_	19a. Informant's Name/Relationship (Type, Print)	ural Route Numb	
	and sealth m 27		ROSLYN S. PRICE/WIFE 10001 DELLCASTLE RD.,	MONTGOM	ERY VILLAGE, MO 20886
סר	Pages 1		20a. Method of Disposition 1 🏋 Burial 2 Cremation 3 Removal from State	Date	20c. Location - City or Town, State
Baltimore,			'4 □ Donation 5 □ Other (Specify) JUDEAN MEM. GARDENS 08/1 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	.0/2005	OLNEY, MARYLAND
Ba	permit. Departr Importe eny inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNER 1091 ROCKVILLE PIK	AL DIREC	CTION, INC.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	c or respiratory a	rrest, Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death) a. Metartata Esphage Condition		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Indian ing Cause (Disease or injury that initiated events b. Due to (or as a consequence of):		
	nd nd transit	Examiner	Cause (Disease or injury that initiated events c.		
760,	icate be executed physician and s the burial-transit	cai Ex	resulting in death) Last Due to (or as a consequence of):		
687			d		
Вох	h certi ending	M/UE	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
О. Ш	The law requires that the death certifica lite has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown 9		Month Day Year
<u>α</u>	that the ed by detac	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contribute to the cause of death?
Records,	quires in sign	ed by		10	Yes 2X No 3 Probably 4 Unknown
900	law requir as been si 2 should	Completed		24a. Was	
œ =	sicien: The law certificate has t irector, page 2 s	Com			med? death? 2 No 1 Tyes 2 No
Vital	Physicien: r this certific ral director,	Be	examiner? Hospital:	ath (Check only o	
ō	Phy r this ral d	: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c, Injury at		dence 6 Other (Specify)
ion	tending I Jeath. tor: After the funer	atio	1 🕽 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No		
Division	after deatl Director: in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Number or Rural Route Number, vn, State)
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune		29a. Certifier TECertifying Physician: To the best of my knowledge, death occurred at the time, date and place	and due to the	20.02/2\-22
	e Hospitel	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and place of the control of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	urred at the time,	date and place, and due to the cause(s)
	To the Vithin 2.	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
7	5		Paul Benny MD060335	-	August 8, 2005
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
	Sta	te	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	0 208	>
	Registr	ar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18 [Prince Philip Only # 327, Clasy, M 31. Date filed (Month, Day, Year) AUG 09 2005 32. Pegistrar's Signature		

			Please T	ype or Prin							•			e.	
			For State	State of Ma	aryland /	-	artment <i>rtificate</i>			Me		giene Reg. Ng	0 0		71 60
			Registrar 1. Decedent's Name (First, Middle, Last)				lincate	OIL		2.	Date of De	ath		3.1	ime of Death
	Physici /Medio		Muhammad Enayet	ur Razzaq	ue						Month Uly 3	0.	2005	ear 1	L:30 A M
7	Examir		4a. Facility Name (If not institution, give				**		Location of Dea	ıth	-	40	. County of		
	Funeral		Shady Grove Adv 5. Social Security Number 6. Sec		spital e(In yrs. last b		If Under 1	Year	rille If Under 24 Hr		Date of Bir	th	9	omery Birthplace (State or Foreign
ш	Director		460-77-0220 ¹ X	M 2□F	52	Yrs.	Months	Days	Hours Min		(Month, Da			Couintry) Banglac	lesh
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. In	side City Limits
	Mary a-f eh	tor	Maryland Monte	omery	Rock	vill	e							11	∐Yes 2∭XNo
	or 28	Director	10e. Street and Number				10f. Zip (10g. Ci	tizen of Wha	at Country?	
	eeth v	eral	10305 Procera D) r 12. Was Decedent E	ver in U.S.	13. V	Vas Decede		0850	Specif	v Yes or No	-		adesh	fian.
9	after d or itam ultra	by Funeral	1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 ☑ N					spanic Origin? () n, Mexican, Pue	rto Ric	an, etc.)		Black,	White, etc.	
5-0036	172 hours after deeth with the Maryland "natural", or itama 23a or 28a-f ehow Sical Examitrer must be myllised at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1		1 ☐ Yes 2	**	Specify:				Specify:	Asia	ın
215-	In 72 t	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		(Give	ient's Usual kind of work DO NOT use	done d	luring most of wo	orking		16b. K	and of Busin	ness/Industry	
212	d within giene. er than "	mo.	Elementary/Secondary (0-12)	College (1-4or 5	+)		Busin	essp	nan				_Self	Emp1c	yed
pu	ba file ital Hy id othe event,	Be	17. Father's Name (First, Middle, Last)						18. Mother's Na	ame (F	irst, Middle,	Maider	Sumame)	•	
Maryland	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "ni any njury or other traumatic event, Item and once.	ည	Abdur Razzaque 19a. Informant's Name/Relationship (Ty	pe. Print)	15	9b. Mailin	a Address	(Street a	Aliy and Number or R		nobta oute Numbe			ate, Zip Çode)
<u>≅</u>	alth ar 27 Is		Muhammad M. Raz		ther	103	05 Pr	ocer	a Dr. R	ock	ville	. MI	2085	0	
Baltimore,	of He Hitem		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ F	<u>-</u>	20b. Place	of Dispos	sition (Name natory or oth	e of		Date				y or Town, S	tate
ţ	t. Pag rtment rtant:		* 4 ☐ Donation 5 ☐ Other (Specify)		Mary	land	Nati	ona]	Cem_J	u1	31, 2	005	Lau	rel, N	TD.
Ba	Department of the sany of the		21. Signature of Funeral Service Licens	Down	200				s of Facility Hi						ne D 20904
(2)			23a. Part1. Enter the disease or coupl shock, or heart failure. List on you	ications that caused	the death. De								r opr	Appr	oximate val Between
	Physician		Immediate Cause (Final disease or condition	3		stol								_	ediate
	/Medical Examiner		resulting in death)	Due to (or as										441.70	
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a	Hyp a consequenc	erte	nsion							Year	*
	a executed den and urial-transit	Examiner	cause. Enter Underlying Cause (Ciseass Or injury that initiated events	S			ial_l	nfar	ction					Hour	s
60,	certificate ba executed iding physicien and ise as the burial-transit		resulting in death) Last	Due to (or as a	a consequenc	e of):									
687	ificate g phys as the	edic		d								-			
Вох	eath certificate ba ex attending physicien for use as the burial	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth		ıth 3□	Ectopic pre	gnancy					23d. Date o Month	,	Year
o.	0 D	ysicl	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 🗆	Other (spe	cify)	<u> </u>				World	Day	1 5041
<u>d</u>	law requires that the de as been signad by the a 2 should be detached f	by Ph	Part II. Other significant conditions con	ntributing to death bu	ıt not resulting	g in the ur	nderlying ca	use give	n in Part I.		23e. Did to	obacco	use contribu	ite to the cau	se of death?
Records,	w requires been sig should b	ted b									1 🗆 1	Yes 2	□ No 3[Probably	4 X Unknown
ecc	ne law re has be ge 2 sho	Completed									24a. Was autop	SV	prio	r to completion	dings available on of cause of
E H	Thate ate											rmed? 2X No	dea 1 🗆	Yes 2 N	lo
Vital	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ★ Yes 2 No	lospital: 1 🔲 Inpatie	nt 2 KER/0	Outoatien	t 3□ DOA	Othe	26. Place of De				6 □Other /	(Specify)	
n of	ding Phye T. After this funeral di	Ju: T	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injur (Month, Day		. Time of		c. Injury Work		1	. Describe h	_			
Division	Attending r death. actor: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be	One Bloom of lain	at Athoma	form attention	M		res 2 □ No	201	Location /	Straat ar	ad Number	or Rural Rout	a Number
Dİ	after of Dirac	Certification;	4 Homicide determined	28e. Place of Inju building, etc	. (Specify)	rarm, stre	eet, ractory,	OHICO		201	City or Tox			nulai nou	e ivaniber,
	To the Hoepital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.	edical C	29a. Certifying Physical Certifying Physical Examination	sician: To the best of no. On the basis of and manner sta	examination a	lge, death and/or inv	occurred a vestigation, i	t the tim	e, date and place pinion, death occ	e, and	due to the	cause(s date and	and manne d place, and	er as stated.	ause(s)
	vithin To the	Me	29b. Signature and title of certifier	/					number					Aonth, Day, Y	
)	4	174	· of	ny				200	5413	9		74	24	30,	2005
	-	100	30. Name and address of person who co	ompleted cause of de 01 Medica				ockv	ille. M	D 2	0850				
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature			2244		-					

DHMH 17 Rev 1/2001

			1 - For State of Registrar		partment of Hertificate of L	ealth and Menta Death	al Hygien Reg. N	Z II II 5	27470
	Physici	ian	Decedent's Name (First, Middle, Last)				te of Death onth D	ay Year	3. Time of Death
	/Medi	cal	Fay Rapisardi	har)	11 CT T	Augu			7,00
	Examir	ner	4a. Facility Name (If not institution, give street and num. Calgary Care Assisted		4b. City, Town, or Silver S			c. County of Deat	
	Funeral		5. Social Security Number 6. Sex 7	. Age (In yrs. last birthda	y) If Under 1 Year		te of Birth onth, Day, Year	ontgomer 9. Birt	y hplace (State or Foreign untry)
	Director		101-07-3179 ^{1□M 2} ▼F	88 Yrs.	Months Days	Hours Min. (Mo	1 1 1	917 Broo	klyn, NY
-	pu k		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	Aaryla f sho	ö							1 ☐ Yes 2 ☑ No
	the 128a-	rect	MD Montgomery 10e. Street and Number	SITVEL	Spring 10f. Zip Code		10g. C	itizen of What Co	untry?
	h with	Funeral Director	1210 Downs Drive		20904		Uni	ted_Stat	A.C.
	deat	ner		ent Ever in U.S. 13		spanic Origin? (Specify Yen, Mexican, Puerto Rican,		14. Race - Ame Black, White	rican Indian,
36	or it	y Fu	1 Never Married 2 Married 1 Yes 2	. ₩ No	1 ☐ Yes 2 ☑ No		,	Specify: Wh	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23e or 28e-f show ther than medical Examinat must be notified at	ed by	3 ₩ Widowed 4 Divorced Year or Dat 15. Decedent's Education		edent's Usual Occupa	tion	16h	Kind of Business/	Industry
15	nin 72 n "ne Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	(Giv	re kind of work done d DO NOT use retired)	uring most of working	135.1		industry .
212	giene giene er the	mo:	10		ng Machine	Operator	Tex	tile/Clo	thing
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (First,		n Sumame)	
Ya	d Men narke	2	Charles Messina	10: 11-		Giovanna Son		T Ot-1- 3	r. 0 / 1
Maryland	d2st th and t7 is n		19a. Informant's Name/Relationship (Type, Print) Sal Rapisardi, Son		-	nd Number or Rural Route .ace, Silver			
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or items 23a or 28a-f show many injury or other treumatic event, the Medical Example must be notified at once.	1 3	20a. Method of Disposition		position (Name of ematory or other place			ocation - City or	
Baltimore,	Page ni: #		1 ☐ Burial 2 ☐ Cremation 3 反 Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	ale		ry 08-10-200)5 Far	mingdale	, NY
alti	mit. partm porte y inju		21. Signature of Funeral Service Ligensee			s of Facility Hines-I			
<u>m</u>	89 = 8	V) -	Normy A. Varcan	1	1800 New H	lampshire Ave	Silve		
			23a. Part1. Enter the clease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not e ch line.	nter the mode of dying	, such as cardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	nd Stage	Dem	ientia			Years
	/Medical Examiner		Due to (o	r as a consequence of).	- Dem steoart	0 -110			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	r as a consequence of):	>1600x +	crites			Years
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
o,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last Due to (o	r as a consequence of):					
8760,	cate b	Physician/Medical	d						
9 ×	eath certifica attending ploor use as t	/Me	IF FEMALE: 23c. If yes, outcome	ome of pregnancy				23d. Date of deli	
Вох	atten d for u	cian	in the past 12 months?	th 2 ☐ Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
0	at the de by the a tached	hys	9 ☐ Unknown 9 ☐ Unknow	vn					
s, P	igned be det	by P	Part II. Other significant conditions contributing to dea	th but not resulting in the	underlying cause give	n in Part I. 23		. 4	the cause of death?
Records,	w require been sky should t						1 ☐ Yes 2	No 3□Pro	obably 4 ☐Unknown
ec	has be	Completed				24	a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
_		S				10	performed? Yes 2 N	death?	2XNo
Vital	Physicien: The this certificate hiral director, page	o Be	25. Was case referred to medical examiner?	of Edition	Othe	26. Place of Death (Chec r. 4 Nursing Home 5		a [7] 011 (2)	7.
of	문 등 교		27. Manner of Death 28a. Date of	oatient 2 ☐ ER/Outpation	of 28c. Injury		Scribe how inju	6 ☐Other (Spec iry occurred	ity)
ion	Attending Fir death. ector: After by the funera	ation	1 Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation	Day Year) Injury		? ′es 2 □ No			
Division	r Attender death	Certification:		f Injury - At home, farm, s	treet, factory, office		cation (Street a		ral Route Number,
0	spitel or At ours after o neret Direc filled in by								
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physician: To the base one) 2 Medical Examiner: On the base and manner	is of examination and/or i	ath occurred at the time investigation, in my opi	e, date and place, and due inion, death occurred at th	to the cause(s e time, date an	s) and manner as d place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Me			29c. License	number	29d. Da	ate signed (Month	, Day, Year)
	7/		PI PI	ycician	D	61067	Ano	just 7	2005
	~		30. Name and address of person who completed cause	of death (Item 23a) (Type	a, Print)		0:	2	20903
			LAURA KHANDAGUE 831	University	Soulevard	East Suite	cs Siwa	er Spring	Maryland
	Sta Registr		29b. Signature and title of certifier 30. Name and address of person who completed cause LAUIZA KHANDAGE 83(31. Date filed (Month, Day, Year) AUG 0 9 2005	gistran's Signature	parti			_	

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner um 10WGV Howard 0 If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex Birthplace (State or Foreign Country) Funeral 1□ M 2XXF Months 089-20-2598 Director New York June 6, Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Depertment of Health end Mental Hygiene "maturel", or items 23s or 28=-1 show any injury or other traumatic event, the Medical Examinar must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Funeral Director Georgia Fayette Peachtree City 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number 113 Boxwood Court 30269 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes ŽXNo Specify: Completed by 3√XWidowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank Teller Financial 17 Fether's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Isaac Goldstein Frances Cohen 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jack Rower - Son 4204 Mellwood Lane; Fairfax VA 22033 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Fairfax Crematory 8/9/05 Fairfax, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Everly Funeral Home Hary TI (se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, VA 22030 a. List only one cause on each line. Part 1. Enter Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of) by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of) within 24 hours after death.

To the Funeral Director: Atter this certificate hes been signed by the etter completely filled in by the funeral director, page 2 should be deteched for u Part II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 3/NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA edicai Certification: To 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature And title of certifier 30. Name and address person who completed cause of deeth (Item 23e) (Type, Print) 10805 KazlowMD 020

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

AUG

09

2005

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Margaret A. Slifer 2005 12:38^p August 4, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F March 22, 1921 Washington, DC Director 577-20-5670 84 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes ₹☐ No Maryland Montgomery Silver Spring Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11401 Charlton Drive USA filed within 72 hours after death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 16b. Kind of Business/Industry National College (1-4or 5+) 2 Is marked other than Elementary/Secondary (0-12) Paper Purchaser Geographic Society other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or <u>ot</u>her traumatic event Be William Martin Slifer, Sr. Dora V. Langyher 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert O. Slifer/Brother 308 Kyle Road, Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 9 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Columbia Gardens Cemetery 2005 Arlington, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licensee 23a. Part I. Ever the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Malignant Pleural Effusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed the burial-transit Bronchoalveolar Lung Carcinoma the attending physician and Due to (or as a consequence of): Physician/Medical d. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 90 Atrial Fibrillation, Hypertension, Osteoporosis 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 1 Yes 2 XNo Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 🔀 No 1₺ Inpatient 2☐ ER/Outpatient 3☐ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 🛎 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 | Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 🔁 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatur August 5, 2005 10 and address of person who co leted cause of death (Item 23a) (Type, Print) 30. Name Elliot Raffel, 5411 Cedar Lane, Gary M.D.

State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) AUG 08 2005 32 Registrar's Signature

DHMH 17 Rev 1/2001

#202A, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 9:28 2005 August /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Arunde ANNAPOLIS Anne MAMPTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 XF Maryland Director 218-90-5551 28, 1963 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. important: if item 27 is marked other than "natural", or itema 23a or 28a-1 show may injury or other traumatic event, it a Modical Examination untilied at 2008. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Tyes 2 XNo Director Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 1144 Hampton Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Printing Broker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles George Griebel III Helen B. Foster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2190 Folwell Avenue St. Paul MN 55108 Helen B. Foster/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 10, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2005 Odenton, Maryland 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 70/25/ Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final o months **Physician** umphoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) signed by the attending physician Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SX Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 1 ☐ Yes 2 No 3 DOA Medical Certification: To After this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No neral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 401 Nor h Broadway, Baltimore, Maryland 2123/ Leslie Kasaman, M.D. 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2005 **Physician** August 3, 4:00 Dale Arden Shaner, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town, or Location of Death Examiner Calvert 1105 El Paso Circle Lusby If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Aug. 9, 1939 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 14 M 2 □ F **Funeral** Months Days Hours Pennsylvania 577-50-0027 65 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d, Inside City Limits 10a State 10h Count 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Calvert Lusby 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ United States Itams 23a 1105 El Paso Circle 20657 death Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 1956—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Exercising Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1958 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Truck / Auto Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Katherine Fetterman John J. Shaner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1105 El Paso Circle, Lusby, Maryland 20657 Mary Ellen Shaner (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 8/06/05 Alexandria, Virginia 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses MOO 542 4405 Broomes Island Rd; Port Republic, MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed burial-transit Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the 35 IF FEMALE use a If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.0. the a 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Tes 21710 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed certificate 1 🗌 Yes 25 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation Natural Accident death. 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide after within 24 hours a To the Funaral C 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 8/3/05 D0059061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Arati Patel, M.D.,

AUG - 5 2005

31. Date filed (Month, Day, Year)

32. Registr s Signature

110 Hospital Rd., Suite #212, Prince Frederick, Maryland 20678

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	Physici		1. Decedent's Name (First, Middle, Last) Kenneth Short	er, S	Sr.		2. Date of Dea Month August	Day Year	3. Time of Death 10:27 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Fort Washington Hospital		4b. City, Town, o	r Location of Deat	h	4c. County of Dec	ath Prince
	Funeral Director		5. Social Security Number 2.1.5 - 2.6 - 0.6.87 Usual Residence of Decedent	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day Sept. 2	h 9. Bi	ithplace (State or Foreign Jountry) aryland
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25. Was case referred to medical examiner? 1 Yes 2 No No 26. Place of Death (Check only one) 27. Manner of Death Natural S Pending investigation 28a. Date of Injury 28b. Time of Injury 28b. Place of Injury 28c. Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury	p eq	by	Part II. Other significant conditions cor	tributing to death but not resulting in t	he underlying cause given in Part I.		_	
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25. Was case referred to medical examiner? 1	page	Com				performed?	death?	
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Harris Harring Mh D-52919 8/2/05	eun	tion	1 Natural 5 ☐ Pending		ury Work?	28d. Describe how inji	iry occurred	
Harris Harring Mh D-52919 8/2/05	* **	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm		28f Location (Street a	nd Number or Rura	l Poute Number
Hames Harring Mh D-52919 8/2/05	y the f	erti	4 Homicide	building, etc. (Specify)	, and an including the second	City or Town, Stat	(e)	nodia ramber,
Humes Harring Mh D-52919 8/2/05	d in by the f	U 1	29a. Certifier (Check only Medical Examin	er. On the basis of examination and/	death occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the cause(sed at the time, date an	s) and manner as st d place, and due to	ated. the cause(s)
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	completely filled in by the f	Medical	29b. Signature and title of certifier	arrene Mh		29d. Da	2/(15	Day, rear)

		For State of Ma		artment of Health and N	Mental Hygie	2000	27478
		1. Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
Physici /Medic		Ezra Herbert Soans			August 6		1:15 P M
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	1
	- 3	Montgomery General Hospit		Olney		Montgome:	
Funeral		13€1M 2□E	e (In yrs. last birthday) O Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	iar) Col	nplace (State or Foreign untry)
Director		212-66-9303	89 Yrs.		June 18,	1916	India
yland sow		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
a-fal	ctor	Maryland Montgomery	Rockvil	le			1 ☐ Yes 2 ☑ No
ith the Marylan or 28a-f show	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	intry?
ath w	ral	18114 Cashell Road		20853		USA	
ours after death with the Maryla purs after death with the Maryla et', or itams 23a or 28a-f ehov	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	t l	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ M 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	,NO	1 ☐ Yes 2★☐ No Specify:		Specify: As:	ian Indian
iffied within 72 hours after death with the Maryland Hygiene. Hygiene. Inter then "naturel", or Items 23e or 28e-f show ent. Ite Madical Examinet must be morified at	ted	15. Decedent's Education	16a. Decer	dent's Usual Occupation	16b	. Kind of Business/l	ndustry
hin 7.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	life. I	kind of work done during most of work DO NOT use retired)	ang		
giene giene er th	Son	3	. 1	rigeraton Enginee		HVAC	
be filed within 72 ho tal Hygiene. Id other then "natu	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid	den Sumame)	
should ind Menin	٩	Unknown Soans		Unknow			
d 2 st th and 7 is n treum		19a. Informant's Name/Relationship (Type, Print) Leelawathi Yamuma Soans/		ng Address (Street and Number or Rui			
1 and Health Health sem 27		20a. Method of Disposition	20b. Place of Dispo	14 Cashell Road, sition (Name of		Location - City or T	
mart: Fig.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	1	natory or other place) A:	ugust 9		
permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If item 27 is marked other then eny Injury or other treumatic event. Item once.		21. Signature of Funeral Service Licensee		Name and Address of Facility rancis J. Collins			Virgninia
Page 3		Volver / Speni		00 University Blv			, MD 20901
COLUMN TO		23a. Part1. En er the disease, or complications that caused shock, or heart failure. List only one cause on each lit	the death. Do not ente				Approximate Interval Between
Physician		Immediate Cause (Final	ubular Necı	rosis			Onset and Death Days
/Medical		resulting in death)	a consequence of):	10313			Days
Examiner		Sequentially list conditions, if any, leading to immediate Due to (or as					
ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Desace or injury) that initiated events c.	a consequence of):				
be executed sician and burial-transit	Examine		a consequence of):				
ate be e hysiciar he buri	cai	d					
The law requires that the death certificate the has been signed by the attending phys page 2 should be detached for use as the	70						
eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth		Ectopic pregnancy		23d. Date of deliv	•
e deal	sicie	1 Yes 2 No		Other (specify)		Month	Day Year
at the ded by the etached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death b	ut ant annuting in the	adad ian assault and t	22a Did tabasa	co use contribute to	the save of death?
ires that signed t	by	Parkinson's Disease	at not resulting at the ur	ndenying cause given in Part i.	1 Yes		bably 4 Unknown
v require been si should l	Completed						opsy findings available
has ge 2	mp				24a. Was an autopsy performed	prior to co death?	ompletion of cause of
	e Co	25. Was case referred to medical		OC Blace of Deep	1 ☐ Yes 2 ☐X	No 1 ☐ Yes	2 No
S :=	0	examiner? 1 ☐ Yes 2 ☒No Hospital: 1 ☒ Inpatie	ent 2 ER/Outpatien	Other	me 5 Residence	6 □Other (Speci	fv)
g Phy er this	n: T	27. Manner of Death 28a. Date of Inju	ry 28b. Time of		28d. Describe how in		.,,,
ath. rr: After	atlo	2 Accident investigation	, roas, injury	M 1 Yes 2 No			
r Atte er de recto by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, et	ury - At home, farm, stre	eet, factory, office	28f. Location (Street City or Town, St		al Route Number,
itelo irs aft led ir	Cer						
To the Hospitel or Attendin, within 24 hours and act death. To the Funerel Director: Att completely filled in by the fun	edical	29a. Certifier (Check only (C	f examination and/or inv	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause red at the time, date a	e(s) and manner as a and place, and due t	stated. to the cause(s)
ro the vithin 2 Fo the complet	Med	one) And manner sta	ned.	29c. License number	294	Date signed (Month,	Day, Year)
	_	> /Ill/ Met					
3		30. Name and address of person who completed cause of d	eath (Item 23a) (Type	D55694		August 8,	2005
				Spring Road, Olne	ey,MD 2083	2	
• Sta	te						
Registr		AUG 0 9 2005	ar's Signature				

			1 - For State Registrar	Stat		land / Dep		t of H	lealth a	and M	lental Hyg		05	276	.79
	Dhusia		1. Decedeni's Name (First, Mide	lle, Last)							2. Date of Death	n Day	Year	3. Time	of Death
	Physic /Medi		Mary Victory	Stohlma	an						August		005	4:49	р м
	Examir		4a. Facility Name (If not institution	on, give street ar	nd number)		4b. City,	Town, or	Location of	of Death		4c. Coun	ty of Deat	h	
			Suburban Hosp	ital				hesc				Mor	ntgom	erv	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 25		yrs. last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day,		9. Birtl	nplace (State untry)	or Foreign
	Director		577-40-6189 Usual Residence of Decedent		8	1 Yrs.					Dec. 1,	1923	Was	hingto	n, DC
	land		10a. State 10b. Count	у	100	. City, Town or Lo	calion							10d. Inside	City Limits
	Mary	ō	Maryland Monte	gomery		Chevy	Chara								s 2 🔀 No
	289 289	Je C	10e. Street and Number	gomery		chevy	101. Zip				10	g. Citizen of	f What Co	untry?	
	3a o	Ö	8700 Jones M	ill Road	l		20	815				USA			
	death ms 2	Funeral Director	11. Marital Status	12. Was	Decedent Ever	in U.S. 13.			ispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	-		ncan Indian,	
ထ	or Ita	F	1X Never Married 2 ☐ Ma	rried 1 🔲	ed Forces? Yes 2X No					i, Puerto	Rican, etc.)	Bl	ack, White	e, elc.	
8	rai', c	l by	3 ☐ Widowed 4 ☐ Divorce	d If Year	es, Give r or Dates:		1 ☐ Yes	ZXI No	Specify:			Spec	ity:Whi	te	
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7	ithin Ber	npi	Elementary/Secondary (0-12)		ege (1-4or 5+)	life.	kind of wor DO NOT us	se retired)		.9				
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E C	be find H	Be	17. Father's Name (First, Middle Frederick Sto								(First, Middle, M	laiden Suma	me)		
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	1 and Health am 27	11 8	Dorothy S. Ega 20a. Method of Disposition	an/ Sist		5632 b. Place of Dispo	West	ern	Avenu		hevy Cha				
0	Pages nent of P ant: If its		1 Burial 2 ☐ Cremation	3 Removal	from State	cemetery, crei	natory or o	ther plac	e)	Augu	st 12,	Oc. Location	-		
Ë.			`4 □Donation 5 □ Other (14	ount Olive		-	!			shing			
Baltimore,	permit. Page Department of Importent: If any injury or		21. Signature of Faneral Service	Licensee	200 Cm	F 5	Rame an ranci 00 Un	d Addres S J. iver	s of Facility Coll sity	ins Blvd	Funeral , W, Sil	Home Lver S	Inc.	g, MD	20901
	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death)	a. Pn	e on each line. eumonia		er the mode	e of dying	g, such as	cardiac o	r respiratory arre	st,		Approxima Interval Be Onset and 2 Weel	atween I Death
8760,	ate be executed thysician and the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (2 is 8 e or injury that initiated events resulting in death) Last	S	ue to (or as a con										
9	tificat ig phy as th	edi													
.O. Box	The law requires that the death certific. Ite has been signed by the attending pl page 2 should be detached for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 🗀 L 4 🗆 F	s, outcome of pre Live birth 2 — P Pregnant at time Unknown	etal death 3	Ectopic pre Other (spe						ate of deliv	ery Day	Year
ds, P	uires that n signed b	by	Part II. Other significant condit	ions contributing	to death but not	resulting in the u	nderlying ca	use give	n in Part I.		23e. Did toba			the cause of	
Vital Records,	law require nas been si e 2 should l	ompieted								_	24a. Was an autopsy		prior to co	opsy findings	
		Co									perform 1 ☐ Yes 2		death?		
Ħ,	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				111			of Death	(Check only one				
 	Physician: this certific ral director,	은	1 ☐ Yes 2 No			2 ☐ ER/Outpatien		and the same of	4 🗆 1401	rsing Hon	ie 5 ☐ Residen	ce 6 □Ot	her (Speci	(ty)	
	Di Te	on:	27. Manner of Dealh 1 X Natural 5 ☐ Pendi	28a. [Date of Injury (Month, Day Yea	r) 28b. Time of Injury	28	3c. Injury Work	at ?	2	8d. Describe how	injury occu	rred		
Sio	Attending r death. actor: After by the funer	cati	2 Accident invest	igation not be			М		′es 2□N	10					
Division		ertification;		nined 289. h	Place of Injury - A building, etc. (Sp	At home, farm, str ecify)	et, factory,	, office		2	 Location (Streetly or Town, 		ber or Rur	al Route Nur	nber,
	ospita hours unara y fille	edical Ce	(Check only 2 Medice	Exeminer: On t	ine basis of exam	knowledge, death nination and/or inv	occurred a	at the time	e, date and	d place, a	nd due to lhe cau	ise(s) and m	anner as s	stated.	s)
	To the He within 24 To tha Fu completel	Med	one) 29b. Signature and tille of certific	апо	manner slated.										
	Z ₹ Z		230. Signature and fille or certific	me		10	29c.	License D37	number 7891			d. Date signe			
	2					- 0)			.091			August	6,	2005	
			30. Name and address of person A. Rajvanshi,	M.D.	121 Cong	ressiona	l Lar		4 09,	Rocl	ville,	MD 208	352		
	Sta Registr	- 3	31. Date filed (Month, Day, Year AUG 0	_	32. Aggistrar's Si	gnature A	arti								

			1 - For State Registrar		State o	of Marylai		artment of F		1		Reg. N	7 17 19) ;	27480
	Physici	an	Decedent's Name (First, M.			يطبيك	RRY				2. Date of De Month	Da	2005 Ye	ar	3. Time of Death 10:21A M
	/Medi	cal	WILLIAM 4a. Facility Name (If not instit		IKLIN			4b. City, Town, o	r Location		July 3		2005 c. County of D)eath	10:211
1	Examir	ner	Shady Grove				al	Rockvi		OI Dealli			Montg		ry
	Funeral		5. Social Security Number	6. Se	x	7. Age (In yrs	. last birthday)	If Under 1 Year	If Under	r 24 Hrs.	8. Date of Bir Month Da June 12	th Vaar	9.	Birthpl	ace (State or Foreign
	Director		217-14-7510		₫м 2□F	85	Yrs.	Months Days	Hours	Min.	June 12	7192	0 _M		land
	and *		Usual Residence of Decedent 10a, State 10b, Con			10c. C	ity, Town or Lo	ocation						10	Od. Inside City Limits
	Manyi 1 sho	ō	MD Mor	itgom	ery		Gait	hersburg							1 X Yes 2 □ No
	r 28a	rect	10e. Street and Number			1		10f. Zip Code				10g. C	itizen of What	t Count	try?
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show fra Mudical Examirier must be notified at	Funeral Director	9902 Killarne	ev Lai	ne #10:	2		208	77				U.S.A.		
	r dea	ıner	11. Marital Status		12. Was Dec Armed Fo 1 Yes	edent Ever in t	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Or an, Mexica	rigin? (Spec in, Puerto F	cify Yes or No Rican, etc.))-	14. Race - A Black, V		
36	s afte	y Fu	1 ☐ Never Married 2 ☐ ☐ Widowed 4 ☐ Divo		1 ☐ Yes If Yes, Gi Year or E	Ve		1 ☐ Yes 💥 No	Specify				Specify: E	3lac	:k
215-0036	tural	Completed by		dent's Edu		ates.	16a. Dece	dent's Usual Occup	ation			16b. H	Kind of Busine	ess/Ind	ustry
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show among highly or other traumatic event, the Mudical Examination and the notified at once.	Be	17. Father's Name (First, Mid							er's Name Elean	(First, Middle) Or Wil		n Sumame)		
yla	d Men narke	2	Franklin				10h Maili	ng Address (Street					os Tour Stat	o Zin	Cadal
Ma	d 2 st th and th s n traun		19a. Informant's Name/Relate					Thornden						18, ZIP	Code)
e,	Heal Heal Hem 2		20a. Method of Disposition	11200		20b.	Place of Dispo	osition (Name of matory or other place			ate		ocation - City	or To	wn, State
m o	Page ent of	À	Nation 2 ☐ Cremat 14 ☐ Donation 5 ☐ Other			State	n Wesl	ev Cem.	1	8/6/2	2005		arksbu		
Baltimore,	mit. I partm portal / Inju		21. Signature of Funeral Sen	$\overline{}$	/_	1	2:	2. Name and Addre	ss of Facili	ity Sno	wden F	une	ral Hor	me,	P.A.
m	P P P P	-	(second	5	Luca	elu		246 N. Was	-0.0				le, MD	20	850
W			23a. Part 1. Enter the disease shock, or heart failure.	e, of compl List only o	ications that one cause on e	caused the dea each line.	Do not en	ter the mode of dyin	g, such as	s cardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)		Due to	(or as a conse			. / /						
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oʻ	an an		resulting in death) Last			(or as a conse	quence of):								
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical			d										
9 xo	leath certifica attending ph I for use as th	/Mec	IF FEMALE:		23c If yes ou	tcome of pregn	ancy						02 d D-11 of	- l	
Bo	atten for us	cian	23b. Was decedent pregnantin the past 12 months?		1 ☐ Live i	oirth 2 ☐ Fet	al death 3	Ectopic pregnancy Other (specify)	,				23d. Date of Month		y Day Year
P.O.	that the de led by the a detached t	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkn			(
۳,	res that signed b	by PI	Part II. Other significant con	ditions co	ntributing to d	eath but not re	sulting in the u	inderlying cause giv	en in Part i	1.	23e. Did t	obacco	use contribut	e to the	e cause of death?
rd	w require been sig should b			<u>-</u>							10,	Yes 2	₩2No 3□] Proba	ıbly 4 □Unknown
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	ate pa	Con									1 Yes	rmed? 2. No	death		25 No
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier Cert (Check only 2 Med	ifying Phy ical Exami	ner: On the b	asis of examin	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	ne, date ar pinion, dea	nd place, <i>a</i> r ath occurre	nd due to the d at the time,	cause(s date an	and manner d place, <i>a</i> nd o	as sta	ited. the cause(s)
	thin 2 the or the or the or the or the	Med	29b. Signature and title of ce	tifier	and man	ner stated.		29c. Licens	e number			29d. Da	ate signed (M	onth, D	Pay, Year)
	\dagger \dagg		•	7	/	Sa	MA	DOI)57	124			8111	4	-
	-1		30. Name and address of per	son who co	ompleted cau:	se of death (Ite	m 23a) (Type,								-
			Dr. Bao, MI) [3600 OI	d Georg	getown	Road Betl	nesda	, MD	20814				
	Sta		31. Date filed (Month, Day, Y	ear)	005 32.	gistrar's Sign	ature	castil							
	Registi	ar	AUU	0 0 L	003	Mus.	N 19								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State	of Mar	yland /	•	irtment of F <i>tificate of</i>			ental Hy	giene Reg. Na	200	5	274	81
	Physici	an	1. Decedent's Name	e (First, Middle, La	it)							2. Date of De Month	Day		Year	3. Time o	
	/Medic	al	SONI		λΕ	TAY	LOR		4b. City, Town, o	a Lagatica		Augus		, 20 County of	05	4:3	5P M
	Examin	er_	4a. Facility Name (I	not institution, give Nursine					Pikes					Balt		re	
F	uneral		5. Social Security N	umber 6. S	ЭX	7. Age	'In yrs. last	birthday)	If Under 1 Year Months Days			8. Date of Bir (Month, Da Nov . 1	1			ace (State	or Foreign
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th the	or 28.	Olrec	10e. Street and Nur	_					10f. Zip Code				-	zen of Wh		try?	
ath w	23a	la l		winlake				140.1		244		- W- V N-		. S . A		an Indian	
III & I & I & 1 O O O O O O O O O O O O O O O O O O	Department or neatin and wenter rygiene. Department of neatin and wenter rygiene. By Injury or other traumatic event, It's Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status1 ☐ Never Marri3 ☐ Widowed	ied 2 Married 4 Divorced	1 □ Ye If Yes.	Decedent Ev I Forces? es 2 X No Give or Dates:	er in U.S.	1	Vas Decedent of H f Yes, sp <i>eci</i> fy Cub □ Yes 2□ X o			Rican, etc.)			, White, e	etc.	
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ith of	han "	Completed	Elementary/Seco		Colleg	e (1-4or 5+)				d)			ш	ome			
	ther t		17. Father's Name	(First, Middle, Last,	ТУ	r		DOM	estic	18. Moth	er's Name	(First, Middle,)		
d be	ked o	To Be	James	L. Har	ris						Vict	oria	Ble	vins			
IVICAL Y	27 Is mai r traumal			Taylor		band			g Address (Street Twinla								244
es ta	T tem		20a. Method of Disp	position	Removal fr	om State			sition (Name of natory or other pla			ate		cation - C	•	-	
Dallillor Dermit. Pages	Tan and and and and and and and and and a		` 4 □ Donation	5 Other (Specif	2	7	Emo:		rove Ce								
permit	Important In		21. Signature of Fu	OMA K	Lu	euO	h	2	46 N. V	Vashi	ngto	n St	Rocl				
				h voisease, or com failure. List only	plications th one cause o	at caused the on each line	ne de ith. [Do not ente	er the mode of dyi	ng, such as	s cardiac or	r respiratory a	rrest,			Approxima Interval Be Onset and	tween
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that t	igned by be deta	by Ph	Part II. Other signif	ficant conditions of	ontributing t	to death but	not resultin	ig in the ur	nderlying cause gr	ven in Part	1.	23e. Did t	obacco u	se contrib	oute to th	e cause of	death?
w requires t	V) TO											10	res 2	No 3	Prob	ably 4 🗆	Unknown
	his certificate has been I director, page 2 shoul	Completed										24a. Was autop perfo	rmed?	pri de	ere autor or to con ath?] Yes	osy findings npletion of c 2 XNo	available cause of
VIICAL Iclan:	ector,	Be	25. Was case refer examiner?		Hospital:				Ott			(Check only o					
Phys.	rthis or	: To	1 ☐ Yes 2 🔀 27. Manner of Deat		28a. Da	Inpatient ate of Injury	28	Outpatien b. Time of	28c. Inju	ry at		ne 5 Resident)	
Attending	tor: After the	ation	1 XNatural 2 ☐ Accident	5 Pending investigation	(A	Month, Day	Year)	Injury	M 1	rk?]Yes 2.⊑]No						
To the Hospital or Attending Physician:	by by	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	200. PI	lace of Injury uilding, etc.	/ • At home (Specify)	, farm, stre	eet, factory, office		2	Bf. Location (: City or Tox			or Rura	Route Nun	mber,
e Hospita	within 24 hours are To the Funeral Di completely filled in	edical (29a. Certifier (Check only one)		niner: On th		xamination		occurred at the ti								s)
To th	To th	Me	29b. Signature and	title of certifier					29c. Licens	se number						Day, Year)	-
10			1	1 No						27569	9		Au	gust	5,	200	5
				en Hett	lemar	n, MD	183	8 Gr	eene T	ree I	Rd Ba	altimo	re,	MD	212	08	
	Sta Registr		31. Date filed (Mon		005	2. pegistrar	s Signature	40	arte								

			1 - For Registrar	State of Ma	-	epartment of Certificate of		•	giene Reg. No.2	
	Physici	an	1. Decedent's Name (First, Middle, Las	0		VARTZ		2. Date of De Month	nath Day Yea	
	/Medic	al	Aa. Facility Name (If not institution, give	street and number)			or Location of Dea	AUGUS	4c. County of D	
	Examin		THE JOHNS HOPK		PITAL		imale		Baltim	
	Funeral				e (In yrs. last birth	day) If Under 1 Yea	r If Under 24 Hr	S 9 Date of Bir	*h 0.6	Birthplace (State or Foreign
	Director		377 20 3000	MM 2□F	73 Yr	s. Months Days	Hours Mir	July 2		Greece
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryl -f sho	tor	D.C. None		Washin	gton				1X Yes 2 □ No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a c		411 Independence	Ave., S.E.		20	0003		U.S.	Α.
	toms	Funerai	11. Marital Status	Was Decedent I Armed Forces?	ever in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Race - Al Black, W	merican Indian, hite, etc.
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:	1957	1 ☐ Yes 2 No	Specify:		0	Thite
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ad other than "natural", or items 23a or 28a-f show of other than "natural", or items 23a or 28a-f show event, the Madical Examples must be notified at		15. Decedent's Ed	ucation	16a. D	ecedent's Usual Occi	pation		16b. Kind of Busine	
215	thin 7: e. e. "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)		+)	Give kind of work doni ife. DO NOT use retir	ed)	7		,
CA	filed wii Hygien other th	Con		College (1-4or 5 5+	Fina	nce and Ad	Y		U.S. Gove	rnment
Maryland	il be fil nital H ad otl	Be	17. Father's Name (First, Middle, Last) Yiannis Vartzikos					me <i>(First, Middl</i> e, ia Klido	Maiden Sumame)	
Ž	should be and Menta a markad umatic ev	၉	19a. Informant's Name/Relationship (T		19h A	Aziling Address /Stree			er, City or Town, State	Zin Code)
S S	alth ar 27 is r trau		Jan Campbell/ Wif						h., D.C. 2	
re,	of Hear Item		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pl		Date 13,	20c. Location - City	
altimore,	Page ment con ury or		1 ♣ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify,			ni,Samos,G	reece 20	005	Samos Isla	
Balt	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 Is marked any injury or other traumatic events		21. Signature of Funeral Service Licens			22. Name and Addi	ess of Facility. D∈ Vashi	Vol Fune Wisconsi Ington, D	ral Home n Ave., N. O.C. 20007	.W.
		N.	23a Part1. Enter the disease, or comp	lications that caused	the death. Do no	t enter the mode of dy				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_	MONIA					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of)		000	_	= 80	
	-Adminior	er	Sequentially list conditions,	Due to (or as a	e my	ELOGER	sow u	en KEn	1A	4 YEARS
	utad I Insit	m	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 43 1	t consequence of					
o ·	exect an and rial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a	consequence of)	:				
8760,	cate be executad ohysician and the burial-transit	dical		d						
		Med	IF FEMALE:			1000				
Вох	ath co	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1☐Live birth	2 Fetal death	3 Ectopic pregnance	гу		23d. Date of d Month	lelivery Day Year
o.	The law requires that the death certificate has basen signed by the attending page 2 should be detached for use as	Completed by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of death	5 ☐ Other (specify)				,
σ.	s that	y Ph	Part II. Other significent conditions co	ntributing to death bu	it not resulting in th	ne underlying cause g	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
of Vital Records,	w requires baan sign should be	ed b	HYPERTENSION	1				1 🗆 Y	∕es 2.2 (No 3	Probably 4 Unknown
eco	law requas baan 2 should	plet						24a. Was autop	an 24b. Were	autopsy findings available
œ	(0	Com						perfo	rmed? death?	completion of cause of es 2 No
Vita V	ician: sertitic ector,	Be	25. Was case referred to medical examiner?	Jacoital:				ath (Check only o	ne)	
of	Phys this ral dii	2	1 Yes 2 No 27. Manner of Death	lospital: 1 🔀 Inpatier		STIBIL 3L DOA			lence 6 Other (Sp	pecify)
ő	ding I th. : After t funer	tlon	1 ★Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inju	ry Wo	rk?]Yes 2 □ No	200. Describe II	low rijury occurred	
Division	Atter or dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farm	. street, factory, office		28f. Location (S	Street and Number or I	Rural Route Number,
٥	tel or rs afte al Dir ed in	Certification:	4 I Hornicoe	building, etc.	. (Зрөспу)			City or Tow	n, State)	
	To the Hospitel or Attending within 24 hours after death. To the Funaral Director: After completely tilled in by tha fune.	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best o ner: On the basis of and manner stat	examination and/o	leath occurred at the to prinvestigation, in my	ime, date and place opinion, death occ	e, and due to the curred at the time, c	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mor	oth, Day, Year)
ł	10		Mergengleniz	ight, me	DICAL DOCT	OR RES	5-000	P	MGNST 4	,2005
			30. Name and address of person who come the control of the control	ompleted cause of de	ath (Item 23a) (Ty	pe, Print)			BALTIMO	RE 21200
			MEGAN COYLEWRIGHT, To 31. Date filed (Month, Day, Year)	20 40	do Cinnotino		NORTH WOL	te stree	TMARYLAX	D +108+
	Sta Registra			05 Siegus	s Signature	parte				

			1- For State Registrar State of Maryland / Department Certificate			ene g. N.2. (1 (1 5	27101
	Physic		1. Decedent's Name (First, Middle, Last)	- Dod.,	2. Date of Death Month	Day Yea	3. Time of Death 9:27PM
	/Med Exami		Suburban Hospital 4b. City, To	own, or Location of Death ethesda	Aug. 3	4c. County of De Mont	
	Funeral Director		5. Social Security Number 467-42-1872 G. Sex 1 M 2 F 7. Age (In yrs. last birthday) 75 Yrs. Usual Residence of Decedent	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Feb • 22	Year) 30 9. B	irthplace (State or Foreign Country) exas
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be inclined at once.	irector	10a. State 10b. County 10c. City, Town or Location		10	g. Citizen of What C	10d. Inside City Limits Yes 2 No
	r death wi	ınerai 🗅	7200 Walkers Mill Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. If Yes, specific	20743 nt of Hispanic Origin? (Sper Cuban, Mexican, Puerto	ecify Yes or No-	U.S.A	erican Indian,
-0036	hours afte tural', or lt	ed by Fu	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No 1950 1 No 195	No Specify:		Black, Wh	lack
21215-0036	ed within 72 giene. er than "na	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Special	done during most of worki retired)	ng	6b. Kind of Busines: 'ederal	,
Maryland	12 should be filed within in and Mental Hygiene. 7 Is marked other than "I traumatic event, Illia Mark	To Be (17. Father's Name (First, Middle, Last) Henry Young		ie Oliv	er	
	1 and 2 sh Health and iem 27 Is m ither traum			Rireet and Number or Rura	Rd Capi	tol Hei	ghts,MD
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		MBurial 2 □ Cremation 3 □ Removal from State '4 □ Degation 5 □ Other (Specify) Cemetery, crematory or other MD Veterans	r place)	./2005	Chelten	ham, MD
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	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multi Organ System Due to (or as a consequence of):	Failure			Interval Between Onset and Death
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.O. Box 68760,	that the death certificate be ed by the attending physic detached for use as the b	hysician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	iancy		23d. Date of del Month	ivery Day Year
Д	v requires that been signed by should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying caus	e given in Part I.			the cause of death?
	The law ate has b page 2 sl	Completed			24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
oţ	ding Physician: Th n. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2\mathbb{Z} No	26. Place of Death Cther: 4 Nursing Hom Injury at 20 Work?	(Check only one)	e 6 □Other (Spec	
ā	or Attendition death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide determined 28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)	1 ☐ Yes 2 ☐ No	8f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the basis of examination and/or investigation, in rand manner stated.	ne time, date and place, ar ny opinion, death occurred	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
)	3		> Stell wilks D	cense number 0063195		Date signed <i>(Month</i> August	
	Sta		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mr. Steven Wills 4700 Morgan Drive 31. Date filed (Month, Day, Year) 33. Registrar's Signature	Chevy Chas	e, MD 2	0815	
	Registr		AUG 0 9 2005				

young, George 2127 8/3/05

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician P^{M} 5:20 August 01 2005 DORIS ZIMMERMAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Rockville Casey House If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 94 Yrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖸 F Director May 2, Brooklyn, NY 124-03-1715 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show important: If item 27 is marked other than "natural", or items 23a or 28e-f show improve or other treumatic event, the Madical Ever mast be notified at once. XXYes 2 □ No Chevy Chase Montgomery MD Direct 10f. Zin Code 10g, Citizen of What Country? 10e. Street and Number United States of America 8100 Connecticut Avenue #911 20815 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes XXNo Specify: Specify: 3 TWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Librarian County Library System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fannie Baxter ပ Julius Levine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burton Zimmerman, Son 7390 Hickory Log Circle, Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Mag Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 08-02-2005 Cheltenham, MD ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee Na 11800 New Hampshire Ave Silver Spring MD 20904 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis resulting in death) /Medical Due to (or as a consequence of): Examiner Clostridium dificle colitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 2 🗆 No detached 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 📉 No 3 ☐ Probably 4 ☐Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has page 2 autopsy performed? 1 Yes 20XNo Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ MOther (Specify) Hospice 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t 5 Pending investigation 1XXNatural 1 🗌 Yes 2 🗆 No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier 1 🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Drive #102 Rockville, MD 20850 Charles Michael Harrison, M.D. 31. Date filed (Month, Day, Year) AUG 05 State 2005 Registrar

			For State Registrar	State of	Maryland	-	irtment of F		ind Me		jiene _{eg. No} 20 () 5	271.96
	Dia	ļù.	Decedent's Name (First, Middle, La	ist)			uncate or	Douin		Date of Deat	th	Year	3. Time of Death
	Physici /Medic	al.	Frances		enka		Ab City Town	a Lanaka a		ugust	3,2005		6:30ат м
	Examin	er	4a. Facility Name (If not institution, given 4878 Church Lane		er)		4b. City, Town, of Galesv:		f Death		4c. County of		del
	Funeral			Sex 7. 1 □ M 2 ☑ F	Age (In yrs. la		If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birth			lace (State or Foreign
	Director		585-14-4900 Usual Residence of Decedent	- X	84	Yrs.					5,1921		klin,MO
	ryland		10a. State 10b. County			, Town or Lo						1	0d. Inside City Limits
:	he Ma 28a-f s	Director	MD		(Galesv	.,						1X Yes 2 No
:	be flied within 72 hours after death with the Maryland Hygiene. d other than "natural", or tems 23a or 28a-f show event, I'm Medical Evar in or must be redified at		10e. Street and Number 4878 Church Lan	e			10f. Zip Code 20765			1	0g. Citizen of W USA	hat Cour	itry?
	ems 2	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S		Vas Decedent of I Yes, specify Cub	Hispanic Orig	in? (Specif	y Yes or No-		- Americ	an Indian,
36	rs afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 If Yes, Give Year or Date	™ No		☐ Yes 2√ No	Specify:		an, o.u.,	Specify:		hite
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an lan	should be nd Mental marked o	To Be	Harvey V. Jones	,					,	riman	raidon damaine	,,	
	2 sh and ia m		19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	g Address (Street	and Number	r or Rural R	oute Number	. City or Town, S	State, Zip	Code)
	1 and Health em 27 ther tr		Georgine Zelenka 20a, Method of Disposition	_/Daught		4878	Church I	Lane,G	alesv		D 20765	iby or To	State
פֿר	Pages nent of int: Fig		1 ☐ Burial 2X☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		ate ce	metery, cren	natory or other pla fort Cres	·			Alexan		
	permit. F Departm Importar any injur		21. Signature of Juneral Service Lice				. Name and Addre	, ,		-	hington		, ,,,,
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õ ×	ding pl	/Med	IF FEMALE:	23c. If yes, outco	me of pregnan	2024							
ROX	death certific attending p	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birti	n 2 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)	4			23d. Date Mont		ry Day Year
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35,	requires that een signed b	byF	Part II. Other significant conditions	contributing to deat	h but not resul	lting in the un	derlying cause giv	ren in Part I.		23e. Did tob			e cause of death?
Hecords,	w requ	letec					-		_	24a. Was ar			
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		BeC	25. Was case referred to medical examiner?					26. Place	of Death (C	1 ☐ Yes 2 Theck only one		Yes	2 L No
0 2	Phys this aldii	ို	1 Yes 2 No	Hospital: 1 Inp		R/Outpatient		4 🗀 Nuis			nce 6 □Other)
כס	th. : After funer	tlon	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of (Month,	Day Year)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 ⊡N	į.	. Describe ho	w injury occurre	d	
Division	r Atter er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of	Injury - At hor, etc. (Specify)	ne, farm, stre	et, factory, office		28f.	Location (Str City or Town	reet and Number	or Aura	Route Number,
5	ortal or oral Di												
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifying Properties 2 Medical Example 1	nysician: To the be miner: On the basi and manner	s of examination	rledge, death on and/or inv	occurred at the tir estigation, in my o	ne, date and pinion, death	place, and occurred a	due to the ca at the time, da	iuse(s) and man ate and place, ar	ner as sta d due to	ated. the cause(s)
	within To th comp	Me	29b. Signature and little of destition	. 16	-		29c. Licens	e number		29	9d. Date signed	(Month, L	Day, Year)
	5		1 11	mille	EN D		103	8475			8/03	100	
			30. Name and address of person who	completed cause	60	00/	JAITH	AVA	E /	BAN	190/1	m	7
:-	Sta Registr		31. Date filed (Month, Day, Year) AUG 09	2005 32. R	istrar's Signatu	H A	selle		,			,	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST Day 2 2 **Physician** DOROTHY J. AMRHINE 5:40a 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** EDENWALD TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07/23/1920 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months MARYLAND 1 M 2 KF 213-14-9180 85 Yrs. **Director** Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont if tiem 27 is marked other then "neturel", or Items 23e or 28e-1 show 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County irel, or Items 23e or 28e-f show Extending to ust be notified at 1 ☐ Yes 2 No Director MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 SOUTHERLY RD 21286 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced WHITE 7 is marked other then "neturel", treumetic event, the Madical Ext Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) 12YRS College (1-4or 5+) HOUSEWIFE HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RICHARD JURGENS CAROLINE MADDIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is eny injury or other tre KAREN J. AMRHINE (DAUGHTER) 49 COLLINWOOD RD MAPLEWOOD, N.J 07040. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MORELAND MEM. PARKO8/25/2005 PARKVILLE, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility eny ir SINSNETSONS CO 21111 Approximate Interval Between onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Zheimer years Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or). Examine inding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown à signed t d be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an breast autopsy 25. Was case referred to medical examiner? 1 Yes Division of Vital Hospitel or Attending Physicien: director Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 3 DQA 2 2 ER/Outpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Ž Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0030717 e of deam (Item 3a) (Type, Print) 30. Name and address of person 6701 CHARLES ALICIA COOL M.D. N. ST. TOWSON, MD. 32. Signature 31. Date filed (Month, Day, Year) State AUG 2 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Wealthie L. Becker August 16, 2005 4:45 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore 5. Social Security Number 219-03-5699 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 1 ☐ M 2K□ F Days Min Yrs. Diřector 11, 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other then "naturel", or items 23s or 28s-f show other treumstic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director Md. Queen Anne Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21617 224 Pondview Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify 3 → Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Maryland 2121 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 years homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be figure of Health and Mental Hant: If Item 27 is marked of John Bealefeld Lillian Block 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 224 Pondview Drive, Centreville, Md. 21617 Carolyn Durkowski/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Crownsville Md. Vet. Cem. 8/19/05 Crownsville, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral-Service Licensee Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End-Stag disease or condition resulting in death) ear /Medical Due to (or as a consequence of) Examiner Dev Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as an sequence of): Examiner The law requires that the death certificate be executed burial-transit physician and resulting in death) Last Due to for as a consequence of) Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year signed by the at d be detached fo 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Syndrome 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performed? 2X No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DDA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury s after decret Atre 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide within 24 hours after de To the Funerel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of cepifier 29c. License number 25205 30. Name and address of person who completed suse of death (Ite 3a) (Type, Print) N. Chal. St 5 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 0 0 5 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 8, 2005 AUGUST **Physician** 9:10F Martha M. Boyce /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death **Examiner** Center Towson 8. Date of Birth (Month, Day, Year, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 82 Months Hours 1 ☐ M 2 ☐ F 213-12-9612 1922 Director Nov. Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Example of the confidence 1 ☑ Yes 2 ☐ No Aberdeen Director Harford Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21001 700 W. Belair Avenue, Apt. 117 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. filed withIn 72 hours after i Hygiene. Yes 2 No 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: If Yes, Givo Year or Dates: 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) clothing (G.E.M.) co-manager 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finand Mental His markad otl Emma Bowman William H. Cook 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
214 Point to Point Square, Bel Air, Md. 21015 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sl ment of Health an ant: if item 27 ia 1 Janice Schuman/daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō permit. Page Department of important: if any injury or once. Holly Hill Mem. Gdns. 8/22/05 Middle River, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature & Faneral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a Party Inter Pant Enter dis se, shock, or he failure. L Approximate Interval Between Onset and Death Immediate Cau (Fina disease or condition resulting in death) Physician CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): **Examiner** CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit ACUTE RENAL FAILURE the attending physiclan and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical d. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably been signature Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 🗌 Yes Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification; To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation 1 🗌 Yes 2 No death. Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29b. Signature and title of bertifier 29c. License number 29d. Date signed (Month, Day, Year) 0 m.10 201 D41410 30. Name an Inddries of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 MEHTA M.D. 7601 JOGINDER P. 32. Registraris Signatu 31. Date filed (Month, Day, Year) State AUG 2 3 2005

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 19a per fh 8846 8-23-05 vt

State of Manyland / Department of Health and Mental Hygiene

			For State Registrar	State of	Marylai				ealth ai Death	nd Me		giene 1eg. No.	20	05	2710
	Physicia		1. Decedent's Name (First, Middle, La Frances Mary Bis	·						2	2. Date of Dea Month 08		200	ear 05	3. Time of Death 08:42a M
	/Medic Examin		4a. Facility Name (If not institution, given 12 Sussex Rd.	e street and num	ber)		4b. Cit		Location of				County of		ry
	Funeral Director		490-03-1874	Sex 7 I□M 2⊠F	'. Age (In yrs 89	. last birthday) Yrs.	If Und Months	Days	If Under 24 Hours	4 Hrs. 8 Min.	B. Date of Birth (Month, Day 04-16-	, Year)	6	Birthpli Count Ken	ace (State or Foreign ry) ntucky
Maryland	f show	ō	Usual Residence of Decedent 10a. State 10b. County MD Monts	omery		ity, Town or Lo		 ng						10	od. Inside City Limits
vith the	be not	Direct	10e. Street and Number	,			_	ip Code					zen of Wha	at Count	ry?
d 21215-0036 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat; or itema 23a or 28a-f show important: if item 27 is marked other than any injury or other traumatic event. The Maritan Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Ford 1 Tes 2 If Yes, Give	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 1 ☐ Yes			20910 Was Decedent of Hispanic Origin? (Specify Yes f Yes, specify Cuban, Mexican, Puerto Rican, e			ify Yes or No- can, etc.)	USA s or No- etc.) 14. Race - American Indian Black, White, etc. Specify: White			itc.
21215-0036 od within 72 hours aft	piene. r than "natur the Medical	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed)				d of work done during most of working NOT use retired)				16b. Kind of Business/Industry Own Home			ustry
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re, Mary s 1 and 2 sho	Health and Item 27 is me other traums		19a. Informant's Name/Relationship Fand Dhanji/sense 20a. Method of Disposition	-in-law	- 1		Suss	ex Rd	. Sil		Route Numbe Spring te	MO 2			
Baltimore, permit. Pages 1 a	partment of sortant: iff i sortant: iff i injury or se.		1 ☐ Burial 2☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lies	fy)	tate (Chesape	ake 2. Name	Crema	tory		22-2005		eltsv		e MD
	oden i due i due ysician		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on ea	used the dea ch line.		er the me	de of dying	g, such as ca	ardiac or I		ng N	rvice D-20		Approximate Interval Between Onset and Death
	Medical physician and provide the purial-transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Extr Due to (c	r as a conse	quence of): Asthma quence of):		dim.	mar y						5 years
Records, P.O. Box 6 The law requires that the death certific	by the attending partached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡ No 9 □ Unknown		th 2 ☐ Fet intat time of	al death 3[∃Ectopic] Other (pregnancy pecify)				2	3d. Date o Month		y Day Year
rds, P quires that	gned se de	by	Part II. Other significent conditions Alzheimer's Deme		ath but not re	sulting in the u	nderlying	cause give	en in Part I.						e cause of death?
Records, The law requires t	ate has been sig page 2 should b	Completed	Congestive Heart	Failure		·					24a. Was a autops perfor	sy	prio dea	r to com	sy findings available pletion of cause of
of Vital Physician: T	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	10		Check only or	10)			
o f	tter this	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of		28b. Time o		28c. Injury Work	4 🗆 19015	28	5 Residented August 1985			(Specify)	
Division at or Attending	ours after death. leral Director: A filled in by the fu	Certification:	3 Suicide 6 Could not to determined	286. Place	of Injury - At h g, etc. (Spec	nome, farm, sti ify)	reet, facto	ry, office		28	f. Location (S. City or Town		Number o	or Rural	Route Number,
he Hospit	within 24 hours after To the Funeral Directory completely filled in by	Medicai (29a. Certifier 1 Certifying P 2 Medical Exe	nysician: To the t miner: On the ba and manne	sis of examin	owledge, deat ation and/or in	vestigatio	n, in my op	pinion, death	place, and occurred	at the time, d	ate and	place, and	due to	the cause(s)
T 0 E	To to	Σ/	29b. Signature and title of certifier HAMME	TTN	ND		2	D39			2		signed (A		ay, Year)
10			30. Name and address of person who Carolyn A. Hamme					E. S	te 226	6 Hya	attsv11	e MI	207	83	
U	Sta	_	31. Date filed (Month, Day, Year)		gistrar's Sign										

	1 - State Registrar				Certi	ficate of	Death		Reg. No:	200	5 271	
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an al	James	Walter E	Seard, Sr.					8	27		2:36	
er	4a. Facility Name	(If not institution, gi	ve street and number)		4	lb. City, Town, o	or Location of Deat	h		County of D	eath	
	Frank			Shital Kosedale e (Inlyrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date							more	
	5. Social Security		Sex 7. Ag 1 X M 2 □ F			Months Days	Hours Min.	(Month, Da	ay, Year)		Birthplace (State or Fi	
	219-50-5 Usual Residence			55				3/12/1	950_	Mai	ryland	
	10a. State	10b. County		10c. City	y, Town or Local	tion					10d. Inside City L	
tor	MD	Baltimo	re	Ros	sedale						1 □ Yes 2	
ire	10e. Street and N	lumber				10f. Zip Code			10g. Citi	izen of What	Country?	
Funeral Director	1224 Spr	ing Avenu	e	21237						.A.		
nel	11. Marital Status		12. Was Decedent Armed Forces?			s Decedent of H	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)	0-		merican Indian, /hite, etc.	
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To Be	Edward B	eard					Florenc	e Stotle	er			
F	19a. Informant's	(Type, Print)		19b. Mailing	Address (Street				r Town, Stat	e, Zip Code)		
	Sharon B	eard / Wi	fe		1224 5	Spring A	venue R	r or Rural Route Number, City or Town, State, Zip Code) Rosedale, MD 21237				
	20a. Method of Di			20b. P	lace of Dispositi emetery, cremat	ion (Name of	1	Date			or Town, State	
		2 Z Cremation 3 [n 5 ☐ Other <i>(Spec</i>	Removal from State		cro Crem		· 1	6/05	Pal+	imoro	, Maryland	
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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	Examin		4a. Facility Name (If not institution, give st	SPITA	4b.	City, Town, or Location of D	_	4c. County of Deat	b V/A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday) If U	nder 1 Year If Under 24 I	Hrs. 8. Date of Birth (Month, Day	Year) Q20 Co	thplace (State or Foreign buntry)
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36	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28e-f show event, I.a Medical Exactions must be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		specify Cuban, Mexican, Pi as 2 No Specify:	Jerto Rican, etc.)	Black, Whit	e, etc.
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212	- E M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	OT use retired)	_	Carl Sai	
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ary	2 should and Men le marke eumatic		19a. Informant's Name/Relationship (Typ		19b/Mailing Ad	dress (Street and Number of		City or Town, State,	Zip Code)
	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 le marke any injury or other treumatic anges.		ROBERT BOYD (BROTHER)	3/0 C	REENWICH	STREET, AT	Oc. Location - City or	Vy. 100 13
timore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition / 1 △ Burial 2 □ Cremation 3 □ Re	moval from State	netery, crematory	or other place)			
altin	permit. Page Department (Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service, License		22. Nan	ne and Address of Facility	BRAUNI T	P. FUNER	A HOME
ñ	Depa Impo any ir		Wietrich	V.Willian	10 27	SEPH HON FULTO	NAVE. BI	ALTO, MA	.21217
E			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the death. e cause on each line.	Do not enter the			st,	Approximate Interval Between Onset and Death
1 80	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	MYO CAK	COLA	INFARE	1101		
*	Examiner				ance or):				
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ds, F	Attending Physicien: The law requires that the death certificate or death. strobath. ector: After this certificate has been signed by the attending physic the funeral director, page 2 should be detached for use as the	ρ	Part II. Other significant conditions conf	nbuting to death but not result	ting in the underly	ring cause given in Part I.		acco use contribute to s 2 □ No 3 □ Pr	
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Division of Vital Records,	I or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, f	actory, office	28f. Location (Str City or Town	eet and Number or Ri , State)	ıral Route Number,
	To the Hospitel or Attending Physicien: The l within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	(Check only 2 Medical Exemin	icien: To the best of my know er: On the basis of examination	ledge, death occion and/or investig	urred at the time, date and p ation, in my opinion, death o	lace, and due to the ca	use(s) and manner as	s stated.
	within 2 within 2 To the f	Med	one) 29b. Signature and title of certifer	and manner stated.		29c. License number	29	d. Date signed (Mont	ћ, Day, Year)
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	show	_	10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	the M.	Director	MD Howard 10e. Street and Number		Savage	10f. Zip	Code		10a.	Citizen of What Cou	1 Yes 2 No
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980	72 hours after death with the Maryland natural; or itams 23e or 28a-f show disal Examilier must be notified at	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 XI If Yes, Give Year or Dates:		13. Was Deceded If Yes, special 1 Yes 2	rfy Cuban, Mex	Origin? (Specify ican, Puerto Rica	Yes or No- an, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	within ene.	Completed	(Specify only highest gra	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Infant 16b. Kind of Business/In (Give kind of work done during most of working life. DO NOT use retired) Infant							
d 2	offied with Hygiene. Other ther	Be Co	17. Father's Name (First, Middle, Last)	11/11			18. Mo	other's Name (Fi	rst, Middle, Maid		
ylar	should be filed ind Mental Hygi s marked othar umatic avant, I	ToB	Frank Edmond Byrn	s, Jr				inda Ru			
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Baltimore,	an eall n 2 ner		20a. Method of Disposition 1XXBurial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State	20b. Place of I	Disposition (Name, crematory or other	e of her place)	Date 8/18/2	200	Location · City or Tourtonsvill	own, State
Balti	permit. Pages 1 Department of H Important: If ital any injury or ott		21. Signature of Funeral Service Licen		100770	Donard 313 Ta	Address of Fa Son Fun 1bott A	cility neral Ho:	me, P.A		20707
	Pnysician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Neona	tal Sep	Sis	of dying, such	as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
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	\		30. Name and a sof person who of Nelson	completed cause of d	eath (Item 23a) (T	ype. Print) The Wol	fe St.	, Balti	nore imi	21287	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 3 20	005 32 Registra	eath (Item 23a) (T 600 No ar's Signature	Sperte					

Baltimore, Maryland 21215-0036

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Physicia							August		Year 7005	1230 PM	
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e Lagitiini	ζ.	Maryland Grene	ral Hos	pital	Baltin	nore	City	N	1/A		
Funeral		1□M 2RF	7. Age (In yrs. last b	* * * * * * * * * * * * * * * * * * * *	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di	ay, Year)	Coul		
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aryland show		10a. State 10b. County	10c. City, Tov	wn or Loc	ation				1	10d. Inside City Limits	
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with th		10e. Street and Number #514			10f. Zip Code	7		10g. Citizen of		ntry?	
eath v	Funerai	1102 Druid Hill Avenu	dent Ever in U.S.	13 W	2121 /as Decedent of His		acity Vac or N	USA 14 Bar		can Indian.	
ifter d	Fun	Armed For 1 Never Married 2 Married 1 Yes If Yes, Give	ces?	If	Yes, specify Cuban	i, Mexican, Puerto	Rican, etc.)	Bla	ck, White,	etc.	
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be filed within 72 hours Ital Hygiene. Ind other than "natural", event, the Mudical Exa	Completed	15. Decedent's Education (Specify only highest grade completed)	168	a. Decede	ent's Usual Occupat ind of work done du O NOT use retired)	tion uring most of work	ing	16b. Kind of B		,	
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id be fental rked c	To Be	Rubin Reaves				Maggie	Pittma	an			
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and 2 ealth m 27 I		Aline Ricks/ Niece								land21229	
Pages 1 nent of H int: If iter		20a. Method of Disposition 1√□ Burial 2 □ Cremation 3 □ Removal from S	State cemete	ery, crem	ition (Name of atory or other place		05	20c. Location	-		
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quires on signi							1 🗆 '	Yes 2□No	3 🗌 Prob	ably 4 Denknown	
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s afte	Certification	Buildin	g, etc. (Specify)				City or Tov	vn, State)			
Hospital	edicai	29a. Certifier (Check only (Ch	sis of examination at	e, death o	occurred at the time	, date and place, nion, death occurr	and due to the	cause(s) and ma	nner as st	ated.	
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Med	one) and manne	er stated.		29c. License			29d. Date signe			
7 × 7 8			, ALI	0	089	498	(7. W. 1 - +	1()	705	
2		30. Name and address of person who completed cause	of death (Item 23a)	(Type, P	rint)	1 10	, ,	14451	18	200	
		Chike Giregory () NWUF	40	MD. C	1/0 Ma	rylan	d Ge	hera	1 Hospital	
Sta		31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature	1	No.	7				,	
Registra	ar	AUG 2 3 2005	eur St	Apa	W.						

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August **Physician** Philandieus ŽŎ, Bryant, Sr. 2005 7:20 \mathbf{A}^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 1323 Inland Drive Forestville
If Under 1 Year If Under 24 Hrs. Prince George's 5. Social Security Number (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) **Funeral** Months Days Hours 12XM 2□ F Yrs 140-38-8030 Director 57 1948 Washinton, D.C. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f ehow ir than "natural", or Itams 23a or 28a-f ehov the Medical Examinar must be notified at 1. Yes 2 □ No Director Prince George's Forrestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 U.S.A. 1323 Inland Dr. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 2 should ba filed within 72 hours after and Mental Hygiene. Is markad other than "natural", or Ita 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver National Distributors or other traumatic event, parmit. Pages 1 and 2 should be fitt Department of Health and Mental Hy Important: If Itam 27 is markad oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mentholieum Bryant, Sr. Margaret Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann L. Bryant - Wife 1323 Inland Dr., Forrestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. 8-26-05 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd., Brentwood, MD 20722 13 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Metastatic pancreatic cancer 2 vears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of): attending physician for use as the buria Records, P.O. Box 68760 death certificate be Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2X No 1 Yes 2 No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: il or Attending Patter death.

Director: After t After 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funaral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) Huand, D-33482 August 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sajeen Anand, M.D. 7343-A Hanover Pkwy., Greenbelt, MD 20770 AUG 2 3 2005 31. Date filed (Month, Day, Year) State Registrar

				State of Marylar	nd / Depa	artment of I	Health and	Mental Hy	giene				
			1 - Stata Registrar		Cei	tificate of	Death		Rag. No.	101	15_	271	96
	Physici	an	Decedent's Name (First, Middle, La.	•				2. Date of Dea Month	ith Day	,	Year	3. Time of	Death
	/Medio		CHRISTOPHER	S.		By	RD	AUGUST	21	20	005	3:10	AM
	Examir		4a. Facility Name (If not institution, give	e street and number)		•	or Location of Dear		4¢. C	County of	f Death		
			THE JOHNS HOPKIN				MORE CI						
	Funeral Director		377-70-0020	ex 7. Age (In yrs. № M 2□F 48	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Day Dec 8	Year)		Count	ace (State o try) nta, G	
	pu 🛦		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	cation					10	d. Inside Ci	ty Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Expuritmer must be notified at ange.	tor	MD		imore							1√∏ Yes	
	r 288	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of Wh	nat Count	try?	
	th wit	aiD	511 Thornfield s	treet		21229			Uni	lted	Stat	tes	
	dea ems	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decedent of I	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No-	14		America White, 6	an Indian,	
36	or its	y Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ No If Yes, Give		I□Yes 2,□No		10 1 1100/1 0101/		Specify: F	:		
8	hours ural',	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:		•					Ame	erican	1
Maryland 21215-0036	"nat	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced	lent's Usual Occup kind of work done	pation during most of wo id)	rking	16b. Kind	d of Busi	iness/Ind	ustry	
7	within ene. than	m C	Elementary/Secondary (0-12)	College (1-4or 5+)			or Verizo		Priv	72+0			
d 2	filled Hygin thar		17. Father's Name (First, Middle, Last)		Tech	iiiCiaii I		me (First, Middle,)		
an	d be ental	To Be	Willie Byrd					Willis		ŕ			
Ž	shoul nd M mari	ř	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Re	ural Route Numbe	r, City or	Town, Si	tate, Zip	Code)	
	nd 2 alth a 27 is		Kristina Byrd Kru	mp (daughter)	1306	West Mo	nroe st.	Phoenix	, AZ	850	007		
Baltimore,	s 1 a of Hea itam othe		20a. Method of Disposition		Place of Dispos	sition (Name of natory or other pla	ce)	Date	20c. Loc	ation - C	ity or Tov	wn, State	
Ë	Page nent c int: If		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify				tery 8/2	25/2005	Bren	twoc	od, N	4D	
alti	mit. partin porta y inju		21. Signature of Fu - ral Service Licen	ee	22	. Name and Addre	ess of Facility F	ort Linco	1n F	uner	al F	lome	
Ö	Depa impo any ii	. 10	Luken Them	-22	340	Ol Blade	nsburg Ro	oad Bren	twoo	d, M	1D 20	722	
	Physician		23a. Part 1. Enter the disease, or compshock, or hear railure. List only immediate Cause (Final disease or condition	olications that caused the deal one cause on each line.					est,			Approximate Interval Bette Onset and I	ween Death
	/Medical		resulting in death)	Due to (or as a consec		ا ۱۱۹۰۱۲	- 17000						
п	Examiner		Sequentially list conditions	b. venoocclu		iver Di	sease				1.	MONTE	`
	₽ ₩	iner	Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec							-	Month	14.
	ate be executed hysician and he burial-transit	Examiner	that initiated events resulting in death) Last	c. B - cell Due to (or as a consec	14MPH	ram ci					5	man-	Phs
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×	it the death certifica by the attending ph lached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregn.	ancy				23	d. Date	of deliver	DV.	
Вох	atter I for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of o	al death 3 🗌	Ectopic pregnancy Other (specify)	у		23	Month		-	Year
o.	the d y the sched	ysi	1 Yes 2 No 9 Unknown	9□ Unknown				Te Tao tau					
a	The law requires that the ste has been signed by the page 2 should be detache	by PI	Part II. Other significant conditions of	ontributing to death but not res	sulting in the un	derlying cause giv	ven in Part I.	23e. Did to	bacco use	e contrib	ute to the	e cause of d	reath?
Records,	quires n sign							1 □ Y	es 2 🔯	No 3	☐ Proba	abiy 4 □l	Jnknown
00	w requir s been si should	Completed						24a. Was a	ın	24b. We	re autop	sy findings	available
Re	The lay	mo						autop: perfor	med?	dea	ath?	npletion of c	ause of
Vital			25. Was case referred to medical				26 Place of Dea	1 ☐ Yes ath (Check only or	No No		Yes :		
<u>=</u>	ysician: is certific director,	o Be	examiner? 1 🗆 Yes 2 No	Hospital: 1X Inpatient 2	ER/Outpatient	3 DOA Oth	ner: 4 Nursing H			Other	(Specify)	
of	g Ph er thi	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur Wor	y at	28d. Describe h					
ioi	Attanding Physician: r death. sctor: After this certific by the funeral director.	atio	1 Natural 5 Pending 2 Accident investigation		Injury		Yes 2 □ No						
Division		tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stre	et, factory, office		28f. Location (S City or Town		Number	or Rural	Route Num	ber,
Ö	ital or rs afti al Dii	Certification:											
	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying Phone 2 ☐ Medical Example 2 ☐ Medic	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the tir estigation, in my o	me, date and place ppinion, death occu	e, and due to the corred at the time, d	ause(s) a ate and p	nd mann lace, and	ner as sta d due to	ated. the cause(s)
	To the within 2. To the complet	Mec	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date	signed (Month, E	Day, Year)	
	F ≤ F Ö		Deroln pak	Q , MEDICAL	POLITIC	RES -	000	P	v6us	57	21	2005	
/	101		30. Name and address of person who o										
2			CAPOLYN DAHLEN.	THE TOHNS H	DPICINS	NUSPITA	L, 600 NO	Rth Wolf	e Stre	at,	Bulha	oze, Mar	Lyland
	Sta Registr	_	31. Date filed (Month, Oay, Year)	32. Registrar's Signa	A A	pace							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month **Physician** 2005 /Medical 4c. County of Death ility Name (If not institution, gi 4b. City, Town, or Location of Death **Examiner** Memorial HIMORE DITO 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplece (State or Foreign Sex 12M 2□F **Funeral** Days Hours Min Yrs. Director Usual Residence of Decedent City, Town or Location the Maryland 10a. State 10d. Inside City Limits if item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Medical Example in must be notified at 1 Yes 2 □ No Director 7m04 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death Funerai Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race American Indian, 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after onent of Heelth and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 2X No 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ SON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City Town, State, Zip Code) 20c Location 20a. Method of Disposition City or Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: if any injury or once. • 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License (110. 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ongestive Heart **Physician** 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dilasted Cerdionyopa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physiclen and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy performed? 2□No Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Yes 2 No i Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitai 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (myan) atrina 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nion Memorial Hospital Baltimore, MD atrina Lemon, M.D 31. Date filed (Month, Day, Yea# 32. Registrar's Signature State Registra DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 5.-Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 5:45 PM **Physician** AUGUST 2005 /Medical 4c. County of Death 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner YEMORIAL TIMORE
If Under 24 Hrs. 8. NION If Under 1 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign cial Security Numbe **Funeral** Days Hours 1 □ M 2 1 F Months Director Usuel Residence of Decedent the Maryland 10b. County 10c. City Town or Location 10d. Inside/City Limits 10a. State 28a-f ahow Examiner must be notified at 1 Nes 2 No MD MUKE Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō ME. 21212 Items 23a Completed by Funeral Pages 1 and 2 should be fited within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Race - American I Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No ō Baltimore, Maryland 21215-0036 Yes, Give 3 Widowed 4 □ Divorced Year or Dates: "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry treumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired)

NURSE ADE al Hygiene. condary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be of Health and Mental Hitem 27 is marked of other treumatic ever KUSE コロロハ 2 e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, NORTH 226 DAVEHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 20a. Method of Disposition 10 1 .30.05 DWINGS MILLS, MARYLAN 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. GARRISON TUREST * 4 ☐ Donation 5 ☐ Other (Specify) VAUGHN C.GREENE FINELTE HIM 22, Name and Address of Facility 21. Signature of Funeral Service Licensee BATO, MO 21212 Approximate fnterval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CRITICAL AORTIC STENOSIS MONTHS /Medical Due to (or as a consequence of): Examiner 5 YEARS CORONARY ALTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospitel or Attending Physician: The law requires that the death certificate be executed MONTH MITRAL REGURGITATION burial-trans and Due to (or as a consequence of): 2 WEEKS Box 68760 attending physicien FALLURE by Physician/Medical RENAL IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?
1 □ Yes 2 ☑ No 2 Fetal death 3 Ectopic pregnancy detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 90 2 No MONARY 3 Probably 4 Unknown HYPERTENSION 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2/2/No 1 ☐ Yes certificate 1 ☐ Yes 2/2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 11/Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA Certification: To this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fniury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MEDICINE ATTENDING 40058349 AUGUST 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3333 NORTH CAUTERT STREET #650 BALTIMORE, MD 21218 EDMUND TORI 0.0 32. Registrar's Signature 31. Date filed (Month, Day, Year) --State Registrar

			1 - For State of Maryl Registrar		artment of F			ene g. N2 () () 5	27500					
	Physic		Decedent's Name (First, Middle, Last) Roald	Blik	svaer	-	2. Date of Death Month August		3. Time of Death 55 8:50A M					
	/Medi Exami		4a. Facility Name (If not institution, give street and number) Smith Care Center		4b. City, Town, o			4c. County of De	eath					
	Funeral Director			rs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, Day,	Year) 9. E	Birthplace (State or Foreign Country)					
	70		Usual Residence of Decedent	City, Town or Lo	cation	ll	November 1	8,1929 Os	lo, Norway					
	Se-f sho	Director	MD Harford		ıgdon				10d. Inside City Limits 1 ☐ Yes 🌠 No					
	th with th	al Dire	10e. Street and Number 1224 Splashing Brooke Dri	ive	10f. Zip Code 210	09	10	g. Citizen of What I	Country?					
980	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or Items 23a or 28e-1 show event, Ite Medical Examinar must be multiled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2X No	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ar Black, Wi Specify: W						
Maryland 21215-0036	I within 72 ho iene. r then "natur I e Medical	To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years	(Give	lent's Usual Occup kind of work done of DO NOT use retired hant Sear	during most of w)	vorking 16	Shipping						
land 2			17. Father's Name (First, Middle, Last) Alfred Bliksvaer	FICIC	nanc bear	18. Mother's N	iame (First, Middle, Ma te F. Jakok							
Mary	nd 2 should by lith and Menta 27 is marked r treumetic ev	1	19a. Informant's Name/Relationship (Type, Print)			and Number or i	Rural Route Number, (City or Town, State,						
Baltimore, I	of Hea of Hea litem		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	Place of Dispos cemetery, cren		e) Aug	just 24,	c. Location - City o	or Town, State					
Balti	permit. Page Department Importent: If eny injury o		21. Signature of Funeral Service Licensee	22 C	Name and Addres	s of Facility uneral	Home Of Du	ındalk.P.	City, MD.					
			7110 Sollers Point Road, Dundalk, Mo 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final											
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a constitution)	equence of):	MENT	14,	ASCUI	<u> </u>	Over Sylend					
	xaminer	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			RICTI	VE LUK	14 1) (SEVS	ENER SYEMS					
/ o	ficate be executed physician and s the burial-transit	Examiner	resulting in death) Last C. Due to (or as a cons	equence of):	1			3 WEEKS						
68760,		edical	d. URIX	ARY 57	BLAD.	POLER +	ALLURGU CATA	7770	8 MONTHS					
P.O. Box (The law requires that the death certil te has been signed by the attending bage 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 23c. If yes, outcome of pregnant at time of the past 12 ☐ Fig. 12 ☐ Fig. 12 ☐ Fig. 13c. If yes, outcome of pregnant at time of the past 12 ☐ Fig. 13c. If yes, outcome of pregnant at time of the past 12 ☐ Fig. 13c. If yes, outcome of pregnant at time of the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes 2 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. 13c. If yes, outcome of pregnant in the past 12 ☐ Fig. If yes, outcome of pregnant in the past 12 ☐ Fig. If yes, outc	nancy etal death 3⊡i	Ectopic pregnancy Other (specify)	1000		23d. Date of de Month	blivery Day Year					
rds, P.	quires that (n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not of the Coffol DEMENT	esulting in the un	derlying cause give	n in Part I.	23e. Did tobac		o the cause of death?					
		Completed					24a. Was an autopsy performed	24b. Were a prior to death?	utopsy findings available completion of cause of					
f Vita	Physicien: The this certificate had director, page	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Ye} \) No Hospital: 1 \(\text{Inpatient} \) 2	☐ ER/Outpatient	3 DOA Othe	_	eath (Check only one) Home 5 Residence		LICISTE D					
Division of	ding T. After funer		27. Manner of Death 1 12/Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe how i		City) _101pt					
DIVI	tel or Attenors after deatles after deatles birector: ed birector: ed in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, stree	et, factory, office		28f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,					
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death nation and/or inve	occurred at the time estigation, in my opi	, date and plac nion, death occ	e, and due to the causurred at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)					
	To the To the Complex of the Complex	Σ	29b. Signature and title or certifier Valance	8 M. F	29c. License		29d.	Date signed (Mont	h, Day, Year)					
	n_{j}		30. Name and address of person who completed cause of death (In PER FECTO C. VALARAD, M. 31. Date filed (Month, Day, Year)	om 23a) (Type, P	rint) HAR FOR	o Ro.	Su. 106 F	KUSTON	MD21047					
	Sta Registr	re		nature					- (